Friends & Family Chiropractic, P.C.
Personal Health History

Personal Information:

Name _____ Date:_____ File #_____
Address_____City/State/zip_____
Date of Birth_____ Age_____Social Security Number_____
Primary Phone_____ Cellular _____ Work_____
Marital Status: S M D W
E-Mail Address_____ Can we email health info? Y/N
Name of Your Employer/Occupation_____
Emergency Contact Person_____ Phone #_____
How did you hear about us? _____

Insurance Company:

_____**Type:**_____
PHONE #: _____ Contact Person:
_____
Policy or I.D. #: _____ Group #: _____
Name of Primary Insured:_____
Date of Birth: _____

Family Information:

Spouse's Name/Age_____ Spouse's Occupation_____
Children's Names & Ages_____
_____

Current/Past Health History:

What is your reason for coming in today?
_____
_____
When did this begin?_____ What was the cause?_____

_____
Describe the intensity of the pain (Circle One): **0 = No Pain 10 = unbearable pain**
0 1 2 3 4 5 6 7 8 9 10

Describe the pain: (Check all that apply)

___Sharp ___Throbbing ___ Numb ___Continuous

___Dull ___Tingling ___Spasm ___Comes/goes

___Achy ___Burning ___Weak ___Radiates

Does this interfere with any of your normal daily activities? Y/N _____
_____

Have you ever had this problem before? Y/N

Have you ever had treatment for this problem before? Y/N (Explain the treatment)
_____

Are you currently on any medications for this problem or for ANY OTHER problem? (Please List All Medications)
_____
_____

Please list any other health concerns that you may want to speak with us about today?
_____
_____

Have you ever seen a chiropractor before: Y/N
If yes, why?_____
Were you satisfied with your care? _____
When was your last visit? _____
Reason for leaving care? _____
_____

Have you ever had any of the following (Please explain when applicable):
Circle One:

Y/N Slips/Falls _____
Y/N Accidents_____
Y/N Broken Bones_____
Y/N Surgery_____
Y/N Repetitive Motions Stress (At home/work)_____
Y/N Stress (Emotional, Family, Work)_____
Y/N Sports injuries_____

Do you have a current/past history of (Please explain when applicable):

Y/N Using Tobacco products _____
Y/N Alcohol products_____
Y/N Caffeine Products _____
Y/N Exercise Routine _____
Your Birth History Information: Was your birth in a hospital setting?
_____
Do you know if your birth was a difficult one? _____
Was the use of forceps necessary?_____
Was the use of vacuum extraction necessary?_____

Symptoms	Present	Past	Father	Mother	Spouse	Child	Explain
Allergies							
Asthma							
Arm/elbow Pain							
Arthritis							
Back Pain							
Cancer							
Diabetes							
Digestive problems							
Dizziness							
Fatigue							
High Blood Pressure							
Headaches							
Heart Trouble							
Jaw Pain							
Menstrual Problems							
Neck/Shoulder pain							
Sinus Trouble							
Scoliosis							
Stroke							

If there is any other information that you feel is relevant please describe it here:

_____

_____

Thank you for thoroughly and completely filling out all of this paperwork. This Information will help us to serve you more adequately!

Friends &Family Chiropractic

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be
working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral
subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes
alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. **100% body function**.

We **DO NOT** offer to diagnose or treat any disease or condition other than vertebral Subluxation. However, if During the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will Advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the Services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral Subluxations.

I do hereby authorize the doctors of Friends & Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments or any other procedure that is
advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether
Results are obtained or not.

I also understand that any sum of money paid by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) **(date)**

Authorization for care of Minor

I hereby agree to allow Friends & Family Chiropractic, P.C. and its doctors to administer care to my son/daughter, as they may deem necessary. I clearly understand and agree that I am personally responsible for payment for all fees charged by Friends & Family Chiropractic, P.C..

Signed: _____ Witnessed: _____ Date: _____