Spinal Health & Wellness
at Family Chiropractic

3105 Limestone Road, Suite 303 Wilmington, DE 19808

Patient Contact

First name	Last name	Initial
Preferred name to be called	How were you referred to our office?	
Street address		
City	State	Zip
Home phone #	Cell phone #	
Work phone#	e-mail	

Patient Personal

Date of Birth / /	Age	Primary Care Provider:	Sex M / F
Status single married partnered widowed		Children Yes / No Ages:	

Emergency Contact

Name	Relationship	Home phone#	Work phone#

Spouse/Guardian

First name	Last name	Initial
Home phone #	Cell phone #	Work phone #

Insurance Guarantor

Name	Date of Birth	Insurance Carrier:

Benefit Assignment/Billing Policy

I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes: 1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy. 2. Amounts owed on my behalf from proceeds of any settlement related to my case. I also understand that any DEDUCTIBLE and/or CO-PAYMENT is due at the time of service. I am responsible for full payment if Family Chiropractic Office and its doctors are not providers for my insurance company. It is my responsibility to know and understand my insurance plan. I agree to be responsible for any amount not covered or denied by my insurance.

_____ _____

Patient or guardian signature date

Information Release

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

_____ _____

Patient or guardian signature date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **FAMILY CHIROPRACTIC OFFICE's** "NOTICE OF PRIVACY PRACTICES", revision date 3/23/2013. As required by the Privacy Regulations, **FAMILY CHIROPRACTIC OFFICE** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction. As required by the Privacy Regulations, I am aware that **FAMILY CHIROPRACTIC OFFICE** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests: ❑ I wish to file a "Request for Restriction" of my Protected Health Information.

❑ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

❑ I wish to object to the following Entities in the "Notice of Privacy Practices": _____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

_____/_____

Signature Date

_____

Print Name

Have you ever been to a chiropractor? Yes or No Pt name: _____ Pt#: _____

If so, when was your last visit? _____

What is your primary complaint? _____

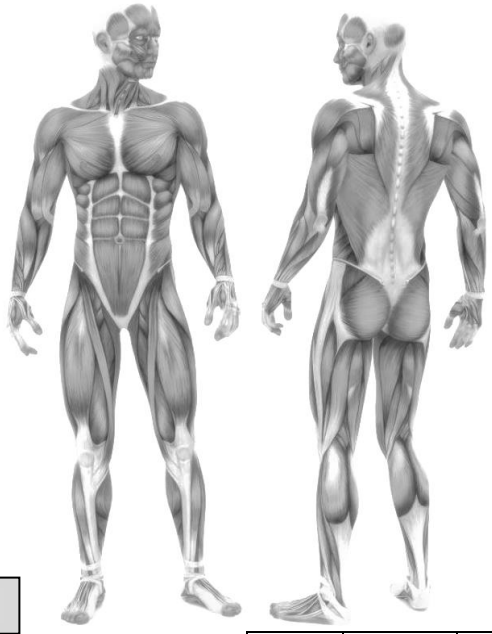
How long have you been experiencing your primary complaint? _____
How does your primary complaint feel? ❑dull/achy ❑sharp ❑numb ❑tingling ❑burning ❑cold
How often do you experience the primary complaint? ❑constantly ❑daily ❑weekly
If you have missed work because of your primary complaint, when was your last day of work? _____
What do you believe is causing your primary complaint? _____
What treatment have you tried for your primary complaint? _____

Have you ever had a lapse of memory? Yes / No Were you ever knocked unconscious? Yes / No
How often do you use tobacco? ❑never ❑daily ❑weekly ❑monthly
How many servings of alcohol do you drink each week? ❑none ❑1-2 ❑ 3-4 ❑5+
Have you ever had any broken bones or dislocations? Yes / No If so, when did it occur and what bone?

List any other health complaints you may have below:

2. _____ 3. _____

Please mark the areas of all of your complaints on the diagrams.



Please use the corresponding symbols to describe any pain.

Stabbing Pain: ////

Burning Pain: 0000

Aching Pain: XXXX

Pins & Needles: ^^^^

Numbness: NNN

How does your condition affect your Activities of Daily Living?

	No effect	Mild effect	Moderate effect	Severe effect			No effect	Mild effect	Moderate effect	Severe effect
Sitting						Household chores				
Standing						Lifting				
Walking						Overhead reach				
Lying down						Bathing/showering				
Bending over						Dressing yourself				
Using stairs						Exercising				
Driving						Sleeping				
Walking up stairs						Love life				
Walking down stairs						Sitting at desk/work				
Turning head						Yard work				
Getting in/out of car						Assisting a family member				

What are your exercise activities? (mark all that apply)

○ Walking ○ Running/ treadmill/cycling	○ Stretching/ flexibility ○ Resistance bands	○ Group exercises classes ○ Weight lifting	○ Yoga/Pilates ○ Swimming/owing

Mark any of the following conditions that pertain to your immediate family history.

	Mother	Father	Sibling		Mother	Father	Sibling
Diabetes				Headaches			
Heart problems				Back pain			
Kidney problems				Obesity			
Cancer				Poor conditioning			

Circle the following conditions as they <u>currently</u> pertain to you.

Alcoholism	Yes / No	Goiter	Yes / No	Mental disorder	Yes / No	Tuberculosis	Yes / No
Anemia	Yes / No	Heart Disease	Yes / No	Mumps	Yes / No	Venereal Infection	Yes / No
Appendicitis	Yes / No	HIV Positive	Yes / No	Pleurisy	Yes / No	Whiplash	Yes / No
Arthritis	Yes / No	Influenza	Yes / No	Pneumonia	Yes / No	Whooping cough	Yes / No
Cancer	Yes / No	Epilepsy	Yes / No	Rheumatic fever	Yes / No	Measles	Yes / No

Have you had an auto accident? Yes / No If so, when was the accident and did you receive treatment?

1_____

2_____

Have you ever had any surgery? Yes / No If so, when and for what?

1_____

2_____

Have you had other injuries playing sports, at work or at home? Yes/ No If so, when, and did you receive treatment?

1_____

2_____

List any prescription or over the counter medications you are currently taking.(Medication & Reason)

1._____

2. _____

3._____

4._____

Mark the following conditions that are <u>currently</u> a cause of significant concern for you.

General				
○ Consistent fainting	○ Chills	○ Convulsions	○ Depression	○ Dizziness
○ Loss of weight	○ Fatigue	○ Fever	○ Headache	○ Loss of sleep
○ Weight gain	○ Neuralgia	○ Night sweats	○ Wheezing	○ Nervousness
Gastro-Intestinal				
○ Constipation	○ Diarrhea	○ Gall bladder problems	○ Hemorrhoids	○ Jaundice
○ Liver problems	○ Nausea	○ Stomach pain	○ Poor appetite	○ Poor digestion
○ Rectal bleeding	○ Vomiting			
Eye/Ear/Nose/Throat				
○ Asthma	○ Enlarged thyroid	○ Tinnitus	○ Earache	○ Ear discharge
○ Nasal obstruction	○ Nose bleeds	○ Frequent colds	○ Hay fever	○ Hoarseness
○ Sore throat	○ Tonsillitis	○ Pain in eyes	○ Poor vision	○ Sinusitis
Respiratory				
○ Chest pain	○ Chronic cough	○ Difficult breathing	○ Spitting blood	○ Spitting phlegm
Muscles/Joints/Bones				
○ Backache	○ Foot problems	○ Pain between shoulders	○ Painful tailbone	○ Stiff neck
○ Spinal curvature	○ Swollen joints	○ Tremors	○ Twitching	○ Weakness
Cardio-Vascular				
○ Ankle swelling	○ High blood pressure	○ Low blood pressure	○ Heart trouble	○ Pain over heart
○ Poor circulation	○ Rapid heart	○ Slow heart	○ Strokes	
Skin or Allergies				
○ Bruise easily	○ Dryness	○ Eczema	○ Hives	○ Itching
Women				
○ Cramps	○ Excessive flow	○ Hot flashes	○ Irregular cycle	○ Painful periods

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services.
- It is my responsibility to complete the office forms accurately.
- Original x-rays are the office's property and digital pictures of the original film(s) and report(s) will be released to me upon written request.

_____ _____

Patient or guardian signature **Date**