Basic Information

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

Date of Birth: _____ Sex: O Male O Female Marital Status? O M O W O D O S

Email: _____ Occupation: _____

Insurance Carrier: _____ Cardholders DOB: _____

Emergency Contact: _____ Phone: _____

Children: O No O Yes / Ages: _____

How were you referred into our office?: _____

Is this a O Wellness visit, or is there a O Specific concern? _____

Have you ever received chiropractic care? O No O Yes When? _____ Who _____

How was your experience?: _____

Do you have any concerns about seeing a chiropractor?: _____

Chiropractic Care

_____***My initials show:*** *I understand Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic evaluates the spine for vertebral subluxation and uses specific adjustments to assist the body in correcting the subluxation in order to restore the body's natural healing ability. We do not diagnose or treat any disease. (We only offer to diagnose and adjust vertebral subluxations). If in the course of the chiropractic examination non-chiropractic or unusual findings are present, you will be advised to seek the services or another health care provider.*

_____***My initials show:*** *I authorize Drs. James and/or Elizabeth Phillip to examine and administer care to my child as they deem appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.*

Insurance

_____***My initials show:*** *I understand and agree that if I have health and/or accident insurance, those policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. I understand and agree that I am personally responsible for payment for services rendered to me. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. It is understood and agreed that the amount paid to the doctor for x-rays is for examination and interpretation only and the actual films remain the property of this office, being on file where they may be viewed.*

_____ ***My initials show:*** *I authorize this health care facility to release all information related to the care I receive, to my HMO, insurance company, third party payer, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.*

Notice of Privacy Practices

_____***My initials show:*** *I further acknowledge that Phillip Family Chiropractic's "Notice of Privacy Practices" has been provided to me. I understand I have a right to review Phillip Family Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of heath care operations of Phillip Family Chiropractic. The Notice of HIPAA Privacy Practices for Phillip Family Chiropractic is also provided on request at the main administration desk of this practice and on the website at www.phillipfamilychiro.com. This Notice of Privacy Practices also describes my rights and Phillip Family Chiropractic's duties with respect to my protected health information. Phillip Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Phillip Family Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.*

Patient/Parent-Guardian Signature: _____ **Date:** _____

Case History

Name: _____ Date: _____

Please fill out the paperwork to the best of your ability. Even if some questions may seem unrelated to your current condition, they all serve a purpose in helping us understand your health and give you the best care possible!

✓ **Please check areas of stress that apply to your life, either in the past (P) as well as current (C).**

P	C	Physical Stress
☐	☐	Birth Trauma
☐	☐	Slips / Falls
☐	☐	Car Accidents
☐	☐	Sports Injuries
☐	☐	Physical Abuse
☐	☐	Work Injuries
☐	☐	Repetitive movements
☐	☐	Poor Posture
☐	☐	Sitting on your wallet
☐	☐	Sleeping position (stomach)
☐	☐	Extensive Computer Work
☐	☐	Heavy purse/backpack
☐	☐	Heavy lifting/bending
☐	☐	Driving for many hours
☐	☐	Continuous sitting/standing
☐	☐	Bone fracture/s
☐	☐	Surgery
☐	☐	Other

P	C	Emotional Stress
☐	☐	Relationships
☐	☐	Work
☐	☐	Children
☐	☐	Money/bills
☐	☐	Homework
☐	☐	Exams
☐	☐	High Stress
☐	☐	Fast paced life
☐	☐	Hold in feelings
☐	☐	Quick tempered
☐	☐	Verbal abuse
☐	☐	Perfectionist
☐	☐	Procrastinator
☐	☐	Sickness/loss of a loved one
☐	☐	Self esteem
☐	☐	Other

P	C	Chemical Stress
☐	☐	Environment
☐	☐	Smoker/second hand
☐	☐	Poor diet
☐	☐	Caffeine—amount?
☐	☐	Excessive sugar
☐	☐	Processed foods
☐	☐	Artificial sweeteners
☐	☐	Conventional meat
☐	☐	Antibiotics
☐	☐	Prescription drugs
☐	☐	Over-the-counter drugs
☐	☐	Recreational drugs
☐	☐	Energy drinks
☐	☐	Fast food
☐	☐	Microwaveable food
☐	☐	Soda
☐	☐	Other

Please list any MAJOR or MINOR accidents, falls and injuries: _____

_____

_____

Sports Injuries: _____

Surgeries: _____

Current medications/drugs (prescription/non-prescription) and what for:

_____

List all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

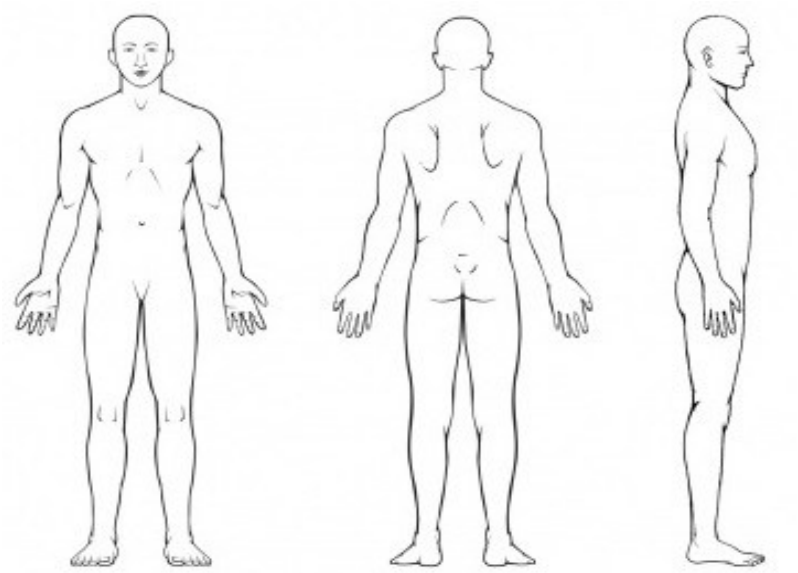
Family History of: O Cancer O Heart Disease O Diabetes O Stroke O Arthritis

✓ **What signals has your body been communicating? P = Past, C = Current**

P	C		P	C		P	C		P	C	
☐	☐	Dizziness	☐	☐	Elbow, Wrist, Hand Pain	☐	☐	IBS (Constipation or Diarrhea)	☐	☐	Disc Problems
☐	☐	Headaches	☐	☐	Arm &/or Hand Numbness	☐	☐	Digestive Disorders	☐	☐	Chronic Fatigue
☐	☐	Ear Infections	☐	☐	Shoulder Pain	☐	☐	Low back Pain	☐	☐	Lupus
☐	☐	TMJ	☐	☐	Mid Back Pain	☐	☐	Sciatica	☐	☐	Fibromyalgia
☐	☐	Neck Pain	☐	☐	Heart Disorders	☐	☐	Leg &/or Feet Numbness	☐	☐	ADD/ADHD
☐	☐	Migraines	☐	☐	Stomach Disorders	☐	☐	Hip Pain	☐	☐	GERD
☐	☐	Sinus Issues	☐	☐	Unexplained Nausea	☐	☐	Leg Pain	☐	☐	Anxiety
☐	☐	Thyroid Issues	☐	☐	Reflux	☐	☐	Knee Pain	☐	☐	Depression
☐	☐	Asthma	☐	☐	Kidney Disorders	☐	☐	Reproductive Disorders	☐	☐	Nervousness
☐	☐	Ulcers	☐	☐	Bladder Problems	☐	☐	Fertility Issues	☐	☐	Epilepsy
☐	☐	Chest Pains	☐	☐	Growing Pains (past)	☐	☐	Menstrual Issues	☐	☐	_____

Present Complaint/s

Please show us the area of your complaint/s by circling the area as accurately as possible.
Be sure to label complaint #1 & complaint #2



Complaint #1 _____

When did the problem/s start? _____

Is the pain: O Constant O Random O Off—and—on O Other: _____

Describe the pain (check all that apply): O Sharp O Dull O Ache O Pinch O Throbbing O Shooting
O Burning O Tightness/stiffness O Tingling O Numbness O Other: _____

Does the pain radiate/travel to other body parts? _____

Rate your Pain: **No Pain 1 2 3 4 5 6 7 8 9 10 Worse Pain**

Is there anything that makes your condition **better**? _____

Is there anything that makes your condition **worse**? _____

When is your condition worse? O Morning O Afternoon O Evening O During the night O No specific time

Is your condition interfering with: O Work O Sleep O Driving O Exercise O Other daily activities: _____

Have you seen anyone else for this condition? _____

Complaint # 2 _____

When did the problem/s start? _____

Is the pain: O Constant O Random O Off—and—on O Other: _____

Describe the pain (check all that apply): O Sharp O Dull O Ache O Pinch O Throbbing O Shooting
O Burning O Tightness/stiffness O Tingling O Numbness O Other: _____

Does the pain radiate/travel to other body parts? _____

Rate your Pain: **No Pain 1 2 3 4 5 6 7 8 9 10 Worse Pain**

Is there anything that makes your condition **better**? _____

Is there anything that makes your condition **worse**? _____

When is your condition worse? O Morning O Afternoon O Evening O During the night O No specific time

Is your condition interfering with: O Work O Sleep O Driving O Exercise O Other daily activities: _____

Have you seen anyone else for this condition? _____

Your Commitment and Goals

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your plan of care . Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ **Patch Care:** Short term relief of pain & discomfort. *(I want the doctor to recommend a short term care plan to get rid of my pain).*
- ☐ **Restoration Care:** Relief of pain & discomfort with correction and restoration of the problem and improvement of overall function in the body. *(I want the doctor to recommend an appropriate schedule to correct my problem and keep it from returning).*
- ☐ **Wellness Care:** After your problems are corrected, you have the option to keep it that way. This type of care occurs after completion of Restoration Care.
- ☐ **Self Controlled Care:** I don't want the doctor to recommend care, I would like to come in on my own schedule when I feel the need to.

Please rate your commitment to your care: *Not Committed* - **1 2 3 4 5 6 7 8 9 10 -** *Very Committed*

What are your 3 goals in receiving care here?

1. _____
2. _____
3. _____

On a scale of 1-10, where do you rate your health at now? *Sick* - **1 2 3 4 5 6 7 8 9 10 -** *Healthy*

On a scale of 1-10, where would you like your health to be? *Sick*- **1 2 3 4 5 6 7 8 9 10 -** *Healthy*

"Chiropractic is Health Insurance... Premiums small, Dividends large!" –B.J. Palmer

I would like to learn more about:

We strive to keep our practice members educated so they can make the best decisions regarding their health. What topics are you interested in learning more about be it via handouts, workshops or general conversations during your adjustments?

☐ Chiropractic for Babies & Kids	☐ Healthy Diet & Nutrition	☐ Living with Less Stress	☐ Shoe Orthotics
☐ Chiropractic for Pregnancy	☐ Exercise & Fitness	☐ Better Posture	☐ Supplements for health
☐ Preconception & Fertility	☐ Proper lifting technique	☐ Essential Oils	☐ Lifestyle Fixer Upper
☐ Core & Pelvic floor Rehab	☐ Chiropractic & Athletics	☐ Raising Healthy Kids	☐ Other:

How long you decide to benefit from chiropractic care is *always up to you!*

Any other questions, comments or concerns? Anything we missed? _____