FAMILYFIRST CHIROPRACTIC

Date: _____ Account #: _____
(for office use only)

PATIENT INFORMATION

Name: _____

Address | City | State | Zip Code: _____

Phone: _____ Email: _____

☐ Male ☐ Female • Preferred Pronoun: _____ ☐ Married ☐ Single ☐ Partnered

DOB: _____ Employer/School: _____

Significant Other's Name: _____ Occupation: _____

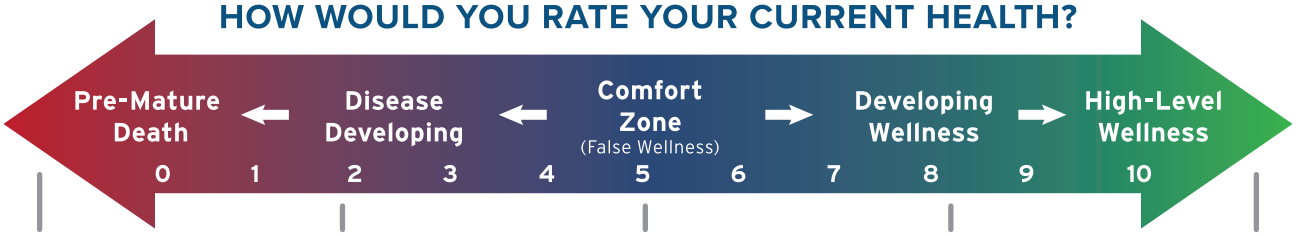
Emergency Contact Name | Relationship | Phone: _____

Have you had Chiropractic Care before? Y / N Date of last Adjustment: _____

Who may we thank for referring you to our practice? _____

Have you or your spouse served in the U.S Military? Y / N

HOW WOULD YOU RATE YOUR CURRENT HEALTH?



DISEASE
Multiple Medications
Poor Quality Of Life
Potential Becomes Limited
Body Has Limited Function

POOR HEALTH
Symptoms
Drug Therapy
Surgery
Losing Normal Function

NEUTRAL
No Symptoms
Nutrition Inconsistent
Exercise Sporadic
Health Not High Priority

GOOD HEALTH
Regular Exercise
Good Nutrition
Wellness Education
Minimal Nerve Interference

OPTIMAL HEALTH
100% Function
Continuous Development
Active Participation
Wellness Lifestyle

What number do you think represents your health today? (1-10 scale as seen above) _____

4 PILLARS OF HEALTH

(check any that apply to you and fill in your own)

EAT WELL: What does your diet mostly consist of?
☐ Organic/Grass Fed ☐ Processed Foods ☐ Home cooked ☐ Eating Out ☐ _____

MOVE WELL: What are your daily movement habits?
☐ Hiking/Outdoors ☐ Yoga ☐ Sedentary ☐ Strength ☐ Walking ☐ _____

THINK WELL: What are your daily mental health strategies?
☐ Meditation ☐ Gratitude ☐ Journaling ☐ Creative Activity ☐ _____

RECOVER WELL: What recovery strategies do you incorporate into your life?
☐ 7+ hours of sleep ☐ Time in Nature ☐ Breathwork ☐ _____

Rank these in order (1-4) of needing improvement for your life at this time (1- highest priority)

_____ Eat Well _____ Move Well _____ Think Well _____ Recover Well

Name: _____ DOB: _____ Account #: _____

REASON FOR SEEKING CHIROPRACTIC CARE

☐ To experience a new level of health and healing

☐ To be more connected to my body

☐ To relieve symptoms **(please mark areas on the diagram to the right)**

☐ Healthy Pregnancy • due date: _____

☐ Other: _____

Current Health Concern:

_____

_____

_____

How long have you been suffering from this?

_____ Days | Weeks | Months | Years

How do you think this began?

_____

What have you done to make it better?

_____

What makes it worse?

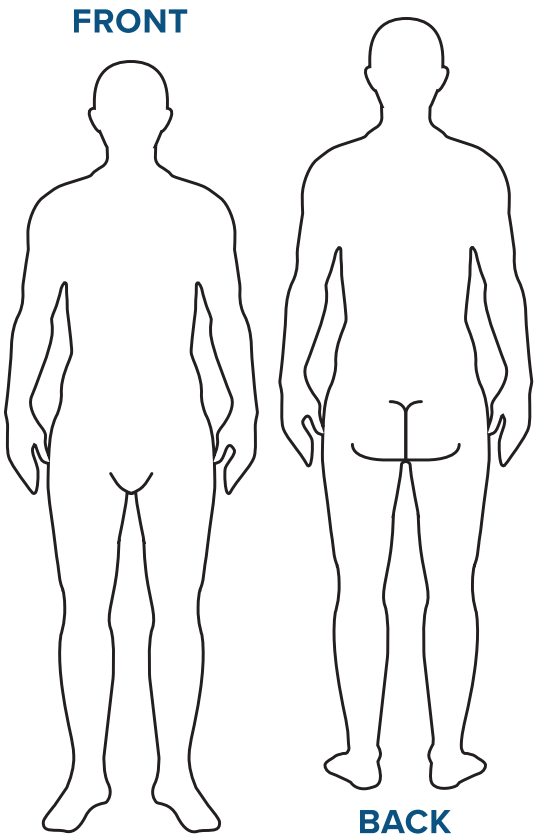
_____

What is the severity of these concerns?

1 2 3 4 5 6 7 8 9 10

How often do you experience these concerns?

☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently



KEY:

X Numb/Tingling

^ Ache/Dull/Stiff

O Burning

– Swelling

> Sharp

Other signs of interference (check any that apply to you)

☐ Headache
☐ Dizziness
☐ Balance Issues
☐ Double Vision
☐ Speech Difficulty
☐ Allergies
☐ Jaw Pain
☐ High Blood Pressure
☐ Sleep Concerns
☐ Seizures/Epilepsy

☐ Heartburn
☐ Acid Reflux
☐ Gall Stones
☐ Kidney Stones
☐ Bladder Infections/UTI
☐ Loss of Bladder Control
☐ Constipation
☐ Diarrhea
☐ Ulcers
☐ Irritable Bowel

☐ Heart Disease
☐ Diabetes
☐ Cancer
☐ HIV/AIDS
☐ Autoimmune Disease
☐ Arthritis
☐ Infertility
☐ Other Health Conditions:

_____

_____

Name: _____ DOB: _____ Account #: _____

THE BODY'S INABILITY TO EXPRESS HEALTH FULLY.

The following can contribute to the nerve interference process.
Please check any that apply to your health history.

Physical Stress

- ☐ Birth Trauma
- ☐ Surgeries
- ☐ Hospitalizations
- ☐ Slip/Fall
- ☐ Motor Vehicle Accident
- ☐ Sports Injuries
- ☐ Concussion
- ☐ Physical Abuse
- ☐ Heavy Physical Labor
- ☐ Poor Posture
- ☐ Heavy Computer Use
- ☐ Repetitive Movements
- ☐ Prolonged Sitting or Standing
- ☐ Sleep Concerns

Emotional Stress

- ☐ Relationships/Family
- ☐ Career
- ☐ Financial
- ☐ Pace of Life
- ☐ Anxiety
- ☐ Depression
- ☐ Quick Temper
- ☐ Overwhelm
- ☐ Emotional Suppression
- ☐ Perfectionism
- ☐ Procrastination
- ☐ Extreme Loss
- ☐ Unworthiness
- ☐ Self Doubt

Chemical Stress

- ☐ Painkillers
- ☐ Smoker/Tobacco
- ☐ Muscle Relaxers
- ☐ 2nd Hand Smoke
- ☐ Caffeine
- ☐ Alcohol
- ☐ Soda
- ☐ "Diet/Sugar Free"
- ☐ Prescription Meds
- ☐ Birth Control/HRT
- ☐ Drugs
- ☐ Processed Foods
- ☐ Antibiotics
- ☐ Hormones

What are the 3 BIGGEST stressors in your life currently?

_____ _____ _____

Allergies	Medications | Purpose	Supplements

CHILDREN'S HEALTH CONCERNS

Number of Past Pregnancies: _____

Children's Names | Ages: _____

Birth History: ☐ OBGYN ☐ Midwife ☐ Hospital ☐ Homebirth ☐ Birthing Center
☐ Natural ☐ Induced ☐ Epidural ☐ Breech ☐ Sunny Side Up ☐ Vacuum ☐ Forceps
☐ Breastfed ☐ Formula ☐ Vaccines ☐ Antibiotics

Health Concerns: ☐ Reflux ☐ Colic ☐ Constipation ☐ Ear Infections ☐ Behavioral ☐ Torticollis
☐ Sleep Concerns ☐ Other _____

_____

_____

Name: _____ DOB: _____ Account #: _____

How is your current health concern interfering with your quality of life?

☐ Work	☐ Sleep	☐ Attitude
☐ Exercise/Recreation	☐ Self-care	☐ Patience
☐ Relationships	☐ Energy	☐ Productivity

What are your HEALTH GOALS?

1. _____

2. _____

3. _____

What is your level of commitment to yourself and your well-being?

1 2 3 4 5 6 7 8 9 10

FAMILY**FIRST**
CHIROPRACTIC

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TOXICITY QUESTIONNAIRE

Designed to aid the practitioner in assessing a patient's potential for nutritional needs.

Rate each of the following based upon your health profile for the past 90 days

CIRCLE THE CORRESPONDING NUMBER

0 Rarely or Never
1 Occasionally Experience the Symptoms, Effect is NOT Severe
2 Occasionally Experience the Symptoms, Effect IS Severe
3 Frequently Experience the Symptoms, Effect is NOT Severe
4 Frequently Experience the Symptoms, Effect IS Severe

DIGESTIVE

Nausea and/or Vomiting	0	1	2	3	4
Diarrhea	0	1	2	3	4
Constipation	0	1	2	3	4
Bloated Feeling	0	1	2	3	4
Belching and/or passing gas	0	1	2	3	4
Heartburn	0	1	2	3	4

TOTAL: _____

EARS

Itchy Ears	0	1	2	3	4
Earaches and/or ear infections	0	1	2	3	4
Drainage from ear	0	1	2	3	4
Ringing in ears and/or hearing loss	0	1	2	3	4

TOTAL: _____

EMOTIONS

Mood swings	0	1	2	3	4
Anxiety, fear, nervousness	0	1	2	3	4
Anger, irritability	0	1	2	3	4
Depression	0	1	2	3	4
Sense of despair	0	1	2	3	4
Uncaring or disinterested	0	1	2	3	4

TOTAL: _____

ENERGY / ACTIVITY

Fatigue and/or sluggishness	0	1	2	3	4
Hyperactivity	0	1	2	3	4
Restlessness	0	1	2	3	4
Insomnia	0	1	2	3	4
Startled awake at night	0	1	2	3	4

TOTAL: _____

EYES

Watery and/or Itchy Eyes	0	1	2	3	4
Swollen, reddened, sticky eyelids	0	1	2	3	4
Dark circled under eyes	0	1	2	3	4
Blurred or tunnel vision	0	1	2	3	4

TOTAL: _____

HEAD

Headaches	0	1	2	3	4
Faintness	0	1	2	3	4
Dizziness	0	1	2	3	4
Pressure	0	1	2	3	4

TOTAL: _____

LUNGS

Chest Congestion	0	1	2	3	4
Asthma and/or bronchitis	0	1	2	3	4
Shortness of breath	0	1	2	3	4
Difficulty breathing	0	1	2	3	4

TOTAL: _____

MIND

Poor memory	0	1	2	3	4
Confusion	0	1	2	3	4
Poor concentration	0	1	2	3	4
Poor coordination	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Stuttering, stammering	0	1	2	3	4
Slurred speech	0	1	2	3	4
Learning disabilities	0	1	2	3	4

TOTAL: _____

MOUTH / THROAT

Chronic coughing	0	1	2	3	4
Gagging or frequent need to clear throat	0	1	2	3	4
Swollen and/or discolored	0	1	2	3	4
Canker sores	0	1	2	3	4

TOTAL: _____

NOSE

Stuffy nose	0	1	2	3	4
Sinus problems	0	1	2	3	4
Hay fever	0	1	2	3	4
Sneezing attacks	0	1	2	3	4
Excessive mucous	0	1	2	3	4

TOTAL: _____

SKIN

Acne	0	1	2	3	4
Hives, rashes, or dry skin	0	1	2	3	4
Hair loss	0	1	2	3	4
Flushing	0	1	2	3	4
Excessive sweating	0	1	2	3	4

TOTAL: _____

HEART

Skipped heartbeats	0	1	2	3	4
Rapid heartbeats	0	1	2	3	4
Chest pain	0	1	2	3	4

TOTAL: _____

JOINTS / MUSCLES

Pain and/or aches in joints	0	1	2	3	4
Rheumatoid arthritis	0	1	2	3	4
Osteoarthritis	0	1	2	3	4
Stiffness and/or limited movement	0	1	2	3	4
Pain and/or aches in muscles	0	1	2	3	4
Recurrent back aches	0	1	2	3	4
Weakness and/or tiredness	0	1	2	3	4

TOTAL: _____

WEIGHT

Binge eating or drinking	0	1	2	3	4
Craving certain foods	0	1	2	3	4
Excessive weight	0	1	2	3	4
Compulsive weight	0	1	2	3	4
Water retention	0	1	2	3	4
Underweight	0	1	2	3	4

TOTAL: _____

OTHER

Frequent illness/sickness	0	1	2	3	4
Frequent or urgent urination	0	1	2	3	4
Leaky bladder	0	1	2	3	4
Genital itch, discharge	0	1	2	3	4

TOTAL: _____

TOTAL: _____

FAMILYFIRST CHIROPRACTIC

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____Last Name: _____

Preferred Language: _____ D.O.B.___/____/_____ Sex: _____

Sex at Birth:_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked CMS requires providers to report both race and ethnicity If yes, start date:_____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

☐ I choose to decline receipt of my clinical summary after every visit.

Patient Signature:_____ Date:_____

For office use only
Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse:_____

Patient Name: _____ D.O.B.:_____ Date:_____

Financial Policies

Proof of Insurance: New patients must complete our new patient information forms before seeing a doctor. We must obtain a copy of your picture ID and current insurance card to have proof of insurance. If you do not provide us with the correct insurance information in a timely manner, you will be responsible for any balance accrued. If your insurance lapses or expires we require full payment within 10 days unless you provide proof of valid insurance coverage.

❑ Self-Pay: Patients without health coverage are expected to make payment in full at the time services are rendered. Any Plan Discounts can only be applied to services paid at the time the services/plans are rendered/initiated. A service charge of 15.00% per annum may be applied to all unpaid balances over sixty days. Financial Hardship is only available upon proof of said hardship and exclusively at the discretion of the doctor.

❑ Medicare: Deductible and/or Co-Insurance is due at time of service when no secondary insurance coverage is available, or benefits cannot be verified. Services not statutorily covered by the Medicare Program are due at the time services are rendered. An Advance Beneficiary Notice will be required for all services not covered or not believed to be covered. Deductibles will be billed and shall be due within ten days. A service charge of 15.00% per annum may be applied to all unpaid balances over sixty days.

In-network plans: I understand Family First Chiropractic will submit claims on by behalf and prepare any necessary reports and forms to assist me in making collection from the insurance company. Family First Chiropractic will accept direct assignment of benefits under this policy and will credit any payments received from insurance company to your account.

I have read and understand the above Financial Policy fully understand that I am ultimately responsible for payment of all services and any costs associated with the collections including but not limited to service charges and other fees for any balance due at to the above office and doctor.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Authorized Representative Name Printed Relationship to patient

Patient Name: _____ DOB: _____ Date: _____

Consent for Care

The process of determining suitability of Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health conditions during the Consultation.

If warranted, a physical examination will be performed that can include but is not limited to: vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress joints of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping tendons) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms.

Radiographs (X Rays) may be taken or ordered to further the Chiropractor's understanding of the underlying condition, positions and alignment of the spine and associated structures. There is limited but present risk to radiation exposure. If you are or think you may be pregnant alert the Chiropractor and/or X ray lab technician; X Rays are not allowed to pregnant women in any trimester.

Privacy Notice Acknowledgment

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I consent to the performance of the above-mentioned procedures performed by the doctor involved in my case: ____ YES _____ NO

I acknowledge that I have been offered a copy of Family First Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

Patient Signature: _____ Date:_____

Witness Signature: _____Date:_____