WELCOME TO FREEPORT FAMILY CHIROPRACTIC & ACUPUNCTURE

Chiropractic Case History/Patient Information

Date__________________ Patient # _______________ **Doctor** ________________

Name _____________________________Social Security # ___________________Home Phone ____________

Address _________________________________City ________________State__________ Zip ______________

E-mail address: _________________________________ Fax # _______________ Cell Phone ______________

Age______ Birth Date_______ Marital: M S W D Spouse's birth date________How many children?_______

Occupation ____________________________________Employer __________________________________

Employer's Address ____ Office Phone___________________

Spouse ____________ Occupation _________________Employer_____________________________________

Name of Nearest Relative__________________________Address____________________Phone _________

How were you referred to our office? ____

Please check any and all insurance coverage that may be applicable in this case**.**
p Major Medical p Worker's Compensation p Medicaid p Medicare p Auto Accident p Other

Name of Primary Insurance Company____

Name of Secondary Insurance Company (if any)____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that a billing charged of $10.00 will be added every 30 days an account is overdue.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature ____ Date___________

Guardian's Signature Authorizing Care ____ Date___________

FFCA proudly offers a free monthly newsletter to our patients. The newsletter keeps you up-to-date with activities at the clinic and the latest health issues. We like to formally welcome our new patients by listing their names in the newsletter. May we list your name in our newsletter? (circle & initial) Yes No _______

Patient Name_______________________________________ date_____________________

Reason for today's visit: ◊ Emergency □ New injury □Old injury □ Chronic Pain □ Wellness visit

Did your injury occur during: □ Work □ Sports/play □ Auto Accident □ Routine/Household activity

When did your condition/accident occur? _____/_____/_____ Where did your injury occur?___________

Please explain what happened____

Is your condition getting worse? □ yes □ no □ constant □ comes and goes

Family Medical Doctor__________________________Has He/She seen you for this condition? Y N

Have you been treated by a chiropractor? Y N If so, Where?____________________________

How frequent is the condition? □Constant □ Daily □ Intermittent □ Night Only

How long does it last? □All Day □ Few Hours □ Minutes

Does it interfere with your: □ Work □ Sleep □ Daily Routine? If so, how:________________________

Are there any other conditions or symptoms that may be related to your major symptom? Y N

If yes, describe ____

Describe the pain: □Sharp □ Dull □ Numbness □ Tingling □ Aching □ Burning □ Stabbing □Other

Is there anything you can do to relieve the problem? Y N If yes, describe ____________________.

If no, what have you tried to do that has not helped? ________________________________

What worsens the condition? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting □Other

Has this or something similar happened in the past? Y N Explain:____________________________

Are you taking any of the following medications? □ Nerve Pills □ Pain Killers □ Muscle relaxers □ Heart

□ Other(s)____

Do you have any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect
Y N Artificail Valves	Y N Alcohol/Drug Abuse	Y N Venereal Diseases	Y N Mitral Valve Prolapse
Y N Hepatitis	Y N Anemia/Diabetes	Y N Cancer	Y N Glaucoma
Y N Sinus Problems	Y N Frequent neck pain	Y N Kidney Problems	Y N Tuberculosis
Y N Ulcers/ Colitis	Y N Psychiatric Problems	Y N Emphysema/Asthma	Y N Chemotherapy
Y N Arthritis	Y N Shingles	Y N Difficulty Breathing	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Artificial Bones/Joints/Implants	Y N Lower Back Problems	
Y N Fainting/Seizures/Epilepsy			

List surgeries w/dates: ____

List any past serious accidents with dates;____

Please list anything that you may be allergic to :______________________________________

Anything else not previously asked/answered____

Are you in pain? Y N please rate your pain with the following scale

NO SYMPTOMS |______________________________________| EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

WOMEN: Are you pregnant? □Yes □ No □ Uncertain

Doctor's Signature _________________________________ Date ____________