Welcome to Manna Family Chiropractic!

Today's date _____ Who should we thank for referring you here?_____

Is your visit today regarding you, or your whole family? ❑Family ❑Just Me

Your name_____ Date of Birth_____

Street Address_____ Apt. # _____

City_____ State_____ Zip_____

Phone_____ Social Security #:_____

❑Single ❑Married E-mail address _____

Employer_____ Phone_____

Will you be using insurance? ❑Yes ❑No Is the insurance yours or your spouse's ❑Mine ❑Spouse's

If your insurance is through your spouse, we need your spouse's name and date of birth_____

Name of Insurance Company _____

Policy number_____ Do we have permission to give your insurance company information about your care here? ❑Yes ❑No (Please give our staff a copy of your insurance card)

Reason for coming in to our office?_____

What has the problem prevented you from doing?_____

How long have you had this problem?_____

Past injuries (car accidents, bad falls, etc.)_____

Describe the pain:	☐ sharp	☐ dull	☐ travels	☐ constant	☐ on & off
Since the onset is the pain:	☐ worse	☐ better	☐ the same		
Does anything make it worse:	☐ standing	☐ sitting	☐ lying	☐ motion	
Are these systems involved?:	☐ digestive	☐ cardiovascular	☐ breathing	☐ elimination	☐ reproductive
Does the pain cause you to:	☐ lose sleep	☐ be short-tempered	☐ miss work	☐ miss play	☐ lose focus

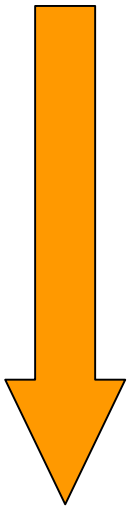
Please check all your symptoms, even if not seemingly related to your complaint…

☐ Headaches	☐ Pins & needles in legs	☐ Back pain	☐ Cold feet
☐ Numbness in fingers	☐ Pins & needles in arms	☐ Dizziness	☐ Neck pain
☐ Numbness in toes	☐ Light bothers eyes	☐ Irritability	☐ Tension
☐ Problem urinating	☐ Menstrual irregularity	☐ Diarrhea	☐ Hot flashes
☐ Mood swings	☐ Buzzing in ears	☐ Heartburn	☐ Cold hands
☐ Sleeping problems	☐ Ringing in ears	☐ Fevers	☐ Fatigue
☐ Stomach upsets	☐ Loss of smell	☐ Fainting	☐ Depression
☐ Loss of balance	☐ Loss of taste	☐ Nervousness	☐ Ulcers

☐ Increased pain when coughing

Personal Wellness Rating: (Please circle one, ten is the most important, one is least important)

How important to you is your overall health?	1 2 3 4 5 6 7 8 9 10
How important to you is exercise?	1 2 3 4 5 6 7 8 9 10
How important to you is getting good rest?	1 2 3 4 5 6 7 8 9 10
How important to you is eating healthy food?	1 2 3 4 5 6 7 8 9 10
How important to you is living the healthiest life you can?	1 2 3 4 5 6 7 8 9 10



Women: Are you pregnant? ❑Yes ❑No
Spouse's name and health status_____
Ever been to a chiropractor? ❑Yes ❑ No Chiropractor's name_____
Last visit? _____ How long were you under care there? _____

Do you exercise? (really?) ❑Yes ❑No If so, describe_____

List current medications:_____
_____
_____

Your Injury History

Ever broken a bone? _____
Play any sports? ❑Yes ❑No What sports? _____
Did you have any bad falls as a child? ❑Yes ❑No
Ever been in any motor vehicle accidents?_____
Any surgeries?_____

Your Personal Family History (Blood relatives only)

History of : ❑Cancer ❑TB ❑Diabetes ❑Stroke ❑Nervous disorders ❑Heart problems
❑Scoliosis ❑High blood pressure ❑Osteoporosis

~TERMS OF ACCEPTANCE~

Manna Family Chiropractic, P.C.

In any healing art, it is important for the doctor and the patient to agree on goals and rules. Cooperation leads to more positive results. *Please make sure that you understand and agree to all of the items below.*

THE GOAL OF CHIROPRACTIC CARE- As practiced in our office, chiropractic consists of the location, analysis, and reduction of the **vertebral subluxations**. This is when the spine is misaligned and causes nerve pressure, which may cause health problems. Our goal is to reposition the spine to a more optimal position to remove or reduce nerve interference. Our guidelines for practice are found in Vertebral Subluxation in Chiropractic Practice© 1998. As all people respond differently to care, we **can never promise** a cure from any condition.

NEW PATIENT ORIENTATION- We like new practice members to attend one 25-minute orientation given on a Tuesday at 5:30 p.m., **or to get that same information** on an audiotape that we can give to you.

1. What you pay (out of your pocket) for care here can be affected by whether or not you belong to a discount health program like **PCD (Preferred Chiropractic Doctor),** what percentage your insurance covers, your insurance deductible, the number of levels of the spine adjusted, and whether you pay at the time of service. The **PCD plan** can save you a significant amount of money…. just ask Kellie about it.

2. **DO UNTO OTHERS-** In the interest of courtesy to other patients here, to my staff, and to me, please notify us beforehand if a particular scheduled visit cannot be kept.

3. **YOUR CARE PLAN WILL BE BASED ON RESEARCH-** Missing just one adjustment can **set your progress back a full week**. If you miss an appointment, you should make up that appointment within a day or two. Otherwise, you will be wasting your time and money.

4. **Family Members-** When you refer people in your family or friends here within two weeks of the date you start, we will charge only **$17** for their exam and x-rays (by law, certain offers cannot be made to Medicare patients; we'll explain).

5. **Informed consent-** The patient/ or guardian of patient agrees to allow the doctor to care for him/ her using standard chiropractic techniques, such as spinal adjustments, trigger-point work, x-rays, or manual traction. Chiropractic is an extremely low-risk form of care. Complications are rare, but can include soreness, dizziness, and temporary increased pain. These usually clear up quickly. Some researchers say that strokes can occur in extremely rare instances (one in several million), while *other researchers say that chiropractic patients actually have half the occurrences of strokes than non-chiropractic patients.*

6. If a patient wants his/ her x-ray films released to them or a health care entity, they must sign a release. The films will then be photographed or copied, and the originals will remain here. We require a three-business days notice to release films, and there may be a $20 copy charge.

I understand the above conditions and agree to them.

Patient or guardian signature _____ **Date**_____

PRIVACY NOTICE

In order to comply with Federal HIPPA laws regarding privacy as it pertains to medical records, we ask your permission on the following items. By signing below, you are agreeing to these privacy terms.

- Of course, if we are billing insurance, we will need to release information to the insurance company about your care.

- On each visit we ask you to sign-in when entering the office. Your signature is legal proof that you were present in the office for care.

- We love referrals! When an existing patient refers someone to us, we sometimes acknowledge him or her by placing their name on the referral board in the office.

- We often place travel cards in a box on the front counter in alphabetical order. The travel cards have some information about you on them, like name, phone number, etc. We ask patients to find their travel card from the box on the front counter when they come in and bring that card back to the adjusting room when your name is called. This really helps Kellie!

- Sometimes we send email newsletters to those of you who have given us email addresses. Otherwise, your email address is never released.

I understand and agree to all of the above.

Signed: _____ Date:_____