NEW PATIENT INFORMATION

NAME: _____(PREFERRED NAME: _____)

(IF UNDER 18 yrs., PARENTS' NAMES: _____)

ADDRESS: _____ CITY _____ STATE/ZIP _____

CELL # _____ HOME# _____(PARENT #_____)

EMERGENCY CONTACT NAME & PHONE: _____

EMAIL: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: M / F SSN: _____

MARITAL STATUS: S / M / D / W SPOUSE NAME: _____

DO YOU HAVE CHILDREN: NO / YES - HOW MANY: _____; AGES OF CHILDREN: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

OCCUPATION: _____EMPLOYER: _____

ARE YOU INSURED? NO / YES: INSURANCE COMPANY NAME: _____

CONSENTS / ACKNOWLEDGEMENTS

- I understand that most care is given in an open adjustment office setting
- I consent to receive communication from the office in connection with my care via postal mail, email, text, & telephone messaging. If I should withdraw my consent, I will notify the office in writing.
- A copy of the privacy policies was given for review & is always available at the front desk.
- This initial visit includes a health history consultation, chiropractic exam and evaluation followed by any initial care that is determined to be clinically necessary and mutually agreed upon.
- The information I have provided on this case history form is true and accurate to the best of my knowledge.
- I give the doctors at Family Chiropractic of Chattanooga permission to render care to me today.
- I agree that I am responsible to pay for all services I receive in this office.
- If this account gets placed with attorney or collections, I am responsible for all fees.
- I assign this office the rights to collect payments from all third-party payors
- I authorize the release of my medical or other information necessary to process claims
- The office will not enter a dispute with your insurance company; we will provide you with information needed
- Emergency/Weekend/After hours appointments will be charged $75.00 (not billed to insurance)
- Missed appointments, without 24-hours' notice, will be charged $15.00

PATIENT'S SIGNATURE: _____ DATE: _____

CONSENT TO TREAT A MINOR: By signing below, I do hereby authorize this office to perform necessary exam & treatment.

Parent / Guardian's Signature Authorizing Care: _____ Date _____

FAMILY CHIROPRACTIC OF CHATTANOOGA
6347 EAST BRAINERD RD, SUITE B
CHATTANOOGA, TN 37421
(423) 355-KIDS(5437)

HEALTH HISTORY

Print Name: _____ Date of birth: _____

TOP THREE CONCERNS FOR SEEKING CHIROPRACTIC **PAIN SCALE (NONE) 0 – 10 (SEVERE)**

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10

ARE YOUR CONCERNS AFFECTING YOUR QUALITY OF DAILY LIFE ACTIVITIES?

Work Y / N School Y / N Walking Y / N Driving Y / N Posture Y / N

Sleeping Y / N Exercise Y / N Sitting Y / N Eating Y / N Sports Y / N

Love Life Y / N Other _____

HAVE YOU CONSULTED, OR DO YOU REGULARLY CONSULT: (Circle ALL that apply)

Medical Physician Naturopath Acupuncturist Homeopath Chiropractor

Massage Therapist Podiatrist Physical Therapist Orthopedist Dentist

PAST SURGICAL HISTORY (Circle all that apply)

Appendectomy Angioplasty Arthroscopic Bladder Biopsy Endoscopy Fracture Gall Bladder Heart bypass

Hysterectomy Kidney stone Pacemaker Spine/back Spinal fusion Thyroidectomy Tonsillectomy Total joint

OTHER: _____

PAST MEDICAL HISTORY (Circle all that apply)

Allergies Alcoholism Anemia Arthritis Asthma Cancer Colitis Diabetes Digestive Disorder

Dizziness/Vertigo Emphysema Endometriosis Epilepsy Fibromyalgia Goiter Gout Heart Trouble

Herpes Hernia High BP High Cholesterol Leukemia Lupus Migraines/HA MVP Mental Condition

Menopause Nervous/Anxiety Obesity Sleeplessness Staph/MRSA Stress Stroke Tuberculosis Ulcers

OTHER: _____

FAMILY HEALTH HISTORY (reference the list above): _____

_____

WOMEN ONLY SECTION:

Pregnant? YES / NO / UNKNOWN Last menstruation date:_____ Due Date: _____

# of births _____ ; # of C-Sections _____; # of miscarriages _____; breast augmentation: reduce / enlarge / mastectomy

PHYSICAL STRESS: (Major traumas from childhood through adult)

Circle all that apply =	Automobile	Motorcycle	Bicycle	Sports	Playground	OTHER
Date of occurrence =	_____	_____	_____	_____	_____	_____

Injuries to body (include broken, fractured, sprained, or painful bones/joints of head, spine, ribs, chest, pelvis/hips, legs/arms)

_____

_____

HEALTH HISTORY (cont.)

Print Name: _____ Date of birth: _____

EMOTIONAL STRESS: (childhood through adult)

Childhood Trauma Y / N	Loss of Loved one Y / N	Abuse Y / N
Work or School Y / N	Divorce / separation Y / N	Financial Y / N
Lifestyle change Y / N	Parents Divorce Y / N	Illness Y / N

CHEMICAL STRESS: (childhood through adult)

Vaccinations Y / N -- vaccine reaction Y / N / unsure

Sensitivities / Allergies -- to what : _____

If consume, circle all that apply -- Caffeine / Tobacco / Alcohol / Rx Drugs / OTC Drugs / Sugar / Dairy

Past or present, regular exposure to: Smoke / Toxic chemicals / Radiation / Drug Therapy / Chemotherapy

Current medications (Rx or OTC) & supplements: _____

_____

CURRENT SYMPTOMS – CIRCLE: (1) MILD / RARE (2) MODERATE / OCCASIONAL (3) SEVERE / CONSTANT

GENERAL HEALTH

1 2 3 Fatigue / Tiredness
1 2 3 Fever / Night Sweats
1 2 3 Trouble Sleeping
1 2 3 Skin Irritations / Rashes / Hives
1 2 3 Bleeding Disorders
1 2 3 Depression
1 2 3 Anxiety / Tension / Stress

EYE, EAR, NOSE, THROAT

1 2 3 Vision / Eye Problems
1 2 3 Hearing / Ear Problems
1 2 3 Throat / Voice / Swallow Problems
1 2 3 Nasal /Sinus Problems
1 2 3 Headaches / Face Pain

GASTROINTESTINAL

1 2 3 Mouth / Stomach Ulcers
1 2 3 Stomach / Abdominal Pains
1 2 3 Diarrhea / Constipation
1 2 3 Vomiting / Nausea
1 2 3 Reflux / Indigestion

GENITOURINARY

1 2 3 Urinary Frequency / Urgency
1 2 3 Urinary Burn /Pain/ Discoloration
1 2 3 Sexual / Reproductive Problems

CARDIOPULMONARY

1 2 3 Breathing Problems
1 2 3 Swelling / Edema
1 2 3 Chest Pains

SKELETAL

1 2 3 Morning Stiffness
1 2 3 Night Pain
1 2 3 Neck Pain
1 2 3 Shoulder / Arm / Wrist / Hand Pain (left / right)
1 2 3 Hip / Leg / Knee / Ankle / Foot Pain (left / right)
1 2 3 Mid-Back / Low Back Pain

NEUROMUSCULAR

1 2 3 Muscle Pain
1 2 3 Muscle Weakness
1 2 3 Numbness / Tingling
1 2 3 Tremors / Shakes
1 2 3 Loss of Consciousness / Passing out

Additional Symptoms you would like to address:

_____

_____

_____

HEALTH HISTORY (cont.)

Print Name: Date of birth:

QUALITY OF LIFE (PRESENTLY)

- How do you grade your physical health? GOOD / FAIR / POOR
- How do you grade your emotional / mental health? GOOD / FAIR / POOR
- How do you rate your overall "quality of life"? GOOD / FAIR / POOR
- Do you exercise regularly? If yes, how often? _____
- Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

- Relief of a symptom or problem Y / N
- Relief AND Prevention of a symptom or problem Y / N
- Healthier spine and nerve system Y / N
- Optimal health on all levels Y / N

My signature below is my agreement that all the information provided on this form is true to the best of my knowledge.

_____

Patient Signature

_____

Today's Date

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