

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____
Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____
Telephone (work) _____ (home) _____ Referred By _____
Age _____ Birth date _____ Social Security # _____ Number of children _____
Occupation _____ Employer _____
Marital Status _____ Spouse's name _____ Spouse's Occupation _____
Spouse's employer _____ Spouse's health status _____
Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* Work Other

Please describe _____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? No Yes If yes, when? _____

List other practioners seen for this injury/condition _____

Have you ever been under chiropractic care? No Yes

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? No Yes Name of company _____

** If an auto accident please provide:*

Insurance company name _____ Contact person _____

Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes
 If yes, please describe _____
 Date of last physical exam: _____ Is there a chance that you are pregnant? No Yes
 Have you had X-rays taken? No Yes If yes, where? _____
 What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

 What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy		Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your symptoms interfere with daily life?	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your symptoms worse during certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do changes in weather affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take vitamin supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What activities aggravate your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Notice of Privacy for:
Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business assoc. sending written assurances for your privacy have been attained.
- Emergency situations. Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- To send out birthday cards and newsletters.

Any other uses or disclosures will only be made with your specific written prior authorizations.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is Krissy and can be reached at FCC regarding privacy issues, to render a complaint to our privacy officer.
- Inspect, copy and amend your protected health information and amend it as allowed by law.

This office reserves the right to change the terms on this notice to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding,

One Time Authorization

I hereby authorize FCC to furnish information to insurance carriers concerning my illness & treatments and I assign to same all payments for medical services rendered to me. I understand that my insurance will be billed as a courtesy and I agree to be financially responsible for any balance due to FCC. I also authorize FCC to perform any treatment which is considered medically necessary by the Dr. A photocopy of the authorization and assignment shall be considered as valid as the original.

CANCELLATION POLICY

If you are unable to keep your scheduled appt. please give 24-hour notice. There will be a \$25:00 charge for every missed or no show appt. Thank you for your cooperation. I acknowledge and understand the above statements.

Signature or Legal Guardian

Date