FAMILY CHIROPRACTIC ASSOCIATES

PATIENT INFORMATION

PLEASE PRINT – THANK YOU!

First Name _____ Middle Initial _____ Last Name _____

Address_____City, State, Zip _____

Primary Phone _____ Home Phone _____ Cell Phone _____

Would you prefer **text** reminders for follow-up appointments? □ **Yes** □ **No**

Date of Birth_____ □ Male □ Female Social Security Number _____

Marital Status □ M □ S □ W □ D Is patient a student □Y □ N

Spouse's Name_____ Spouse's Date of Birth _____Spouse's SSN _____

Emergency Contact _____Phone _____

EMPLOYMENT INFORMATION

Patient's Employer _____Work Phone _____ Ext _____

FINANCIAL RESPONSIBILITY

I have read and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I agree that Family Chiropractic Associates will prepare any necessary reports and forms to assist me in collecting from my insurance company. Any amount authorized to be paid directly to Family Chiropractic Associates will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I end or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

By signing below, you acknowledge your financial responsibility as stated above.

CONSENT FOR PHYSICIAN TO PROCEED WITH TREATMENT

I understand that if I am accepted as a patient by physicians of Family Chiropractic Associates, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me at my request.

By signing below, you acknowledge your consent to proceed with treatment as stated above.

HIPAA PRIVACY PRACTICE NOTICE

- Is required by federal law to maintain the privacy of your Personal Health History and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your Personal Health History.
- Under the privacy rule, may be required by State Law to grant greater access or maintain greater restrictions provided under federal law.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all your Personal Health History that is maintained.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

By signing my name below, I acknowledge that I have received or was offered a copy of the Privacy Practices Notice from Family Chiropractic Associates.

To enable us to share information, such as appointments, balance and/or treatment plan with specific family members or friends, please list below those individuals with whom your protected health information can be shared.

□ **Check the box if you choose <u>NOT</u> to list anyone. DO NOT LIST YOURSELF.**

Name_____ **Relationship**_____

Name_____ **Relationship**_____

Name_____ **Relationship**_____

PATIENT NAME (*PRINT*)_____ **Today's Date**_____

Signature _____

Print / Sign Name of Personal Representative _____

Authority of Personal Representative to Sign for Patient □ **Parent** □ **Guardian** □ **Power of Attorney**

LATE ARRIVALS/NO SHOWS

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call at least ***four*** hours in advance to cancel an appointment, you may be preventing another patient from getting much-needed treatment. On the other hand, the situation may arise where another patient fails to cancel, and we are unable to schedule you for an appointment due to a seemingly "full" schedule.

CANCELLATIONS

Appointments are in high demand and your early cancellation may give another patient the opportunity to schedule a much-needed appointment.

NO SHOWS

Anyone who either forgets or consciously chooses to forgo their scheduled appointment time will be charged ***$25.00 for the first occurrence and $50.00 for each additional occurrence***.
As this fee is not billed to any insurance company, the patient accepts full responsibly to pay this fee prior to scheduling another appointment.

LATE ARRIVALS

If you happen to arrive late for an appointment, your visits may likely be shortened. Depending on how late you arrive, your doctor will have to determine if there is enough time for you to be seen.

HOW TO CANCEL AN APPOINTMENT

To cancel appointments, please call the office at 260-925-6686. If you do not reach the receptionist, you may leave a detailed message. If you would like to reschedule your appointment, we will return your call and give you the next available appointment.

Out of respect and consideration for your doctor and other patients, please plan accordingly.

PATIENT'S NAME (PRINT)_____ **DATE** _____

PATIENT'S/GUARDIAN'S SIGNATURE _____

REVISED 1/2025

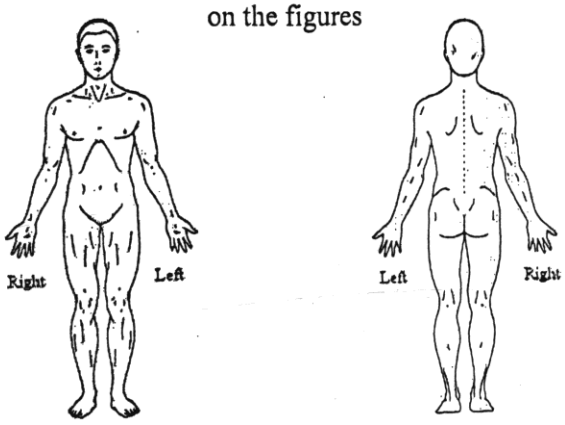
FAMILY CHIROPRACTIC ASSOCIATES

Name _____

Chief Complaint _____

Today's Date _____

Please mark your areas of pain on the figures



1. When did it start? (Date) _____
2. Did it begin suddenly or gradually? _____
3. Did anything cause the onset? YES NO
   If so, what? _____
4. Have you ever had anything like this before? _____
5. Does it radiate to another part of your body? YES NO
   If so, where? _____
6. Describe the sensation **(Circle all that applies)**
   Dull, sharp, stabbing, burning, aching, shooting, numbness, tingling or other _____
7. Rate the intensity 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 (0= NO pain 10=worse pain)
8. Has your condition ____ Improved _____ Worsened _____ Same
9. Have you found anything that makes it better? YES NO
   (rest, ice, heat) _____
10. Does anything seem to make it worse? YES NO
    (activities, coughing, morning, night) _____
11. Has there been any changes in your bodily functions? YES NO
    (Urination, respiration, digestion, bowel, vision)
12. Has your condition affected daily activities? YES NO
    If so, in what way? _____
13. Have you tried any store bought or home remedies? YES NO
    If so, what? _____
14. Have you sought any other professional care for this? YES NO
    If so, whom and what procedures were performed _____
15. Have you had XRAY / MRI to the problem area(s)? YES NO
    If so, when / where? _____
16. Do you have any other symptoms or problems? YES NO
    If so, what? _____

MEDICAL HISTORY

CHECK IF YOU ***HAVE EVER HAD*** ANY OF THE FOLLOWING CONDITIONS / DISEASES

- □ Alcohol / Drug Abuse
- □ Allergies **(Specify)** _____
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Cancer **(Specify)** _____
- □ Chemotherapy
- □ Diabetes
- □ Dizziness / Fainting
- □ Emphysema
- □ Fibromyalgia
- □ Headaches
- □ Heart Attack
- □ Heart Defect-Congenital
- □ Heart Murmur
- □ Heart Surgery / Pacemaker
- □ Hepatitis
- □ High Blood Pressure
- □ Hip Pain
- □ Kidney Problems
- □ Knee Pain
- □ Leg Pain
- □ Lower Back Pain
- □ Mid Back Pain
- □ Neck Pain
- □ Seizures / Epilepsy **(Circle one)**
- □ Shingles
- □ Shoulder Pain
- □ Sinus Problems
- □ Stroke
- □ Thyroid (Hypo / Hyper) **(Circle one)**
- □ Ulcers / Colitis **(Circle one)**
- □ Upper Back Pain
- □ Other_____

FAMILY HISTORY

- □ Arthritis
- □ Cancer
- □ Diabetes
- □ Heart problems / Stroke
- □ High Blood Pressure
- □ Other_____

LIST ALL PREVIOUS SURGERIES / FRACTURES

Date _____ Procedure _____

Date _____ Procedure _____

Date _____ Procedure _____

Date _____ Procedure _____

Date _____ Procedure _____

LIST ANY OTHER SERIOUS MEDICAL CONDITIONS OR DISEASES *(PAST OR PRESENT)*

_____

_____

LIST ALL MEDICATIONS *INCLUDING VITAMINS AND OVER THE COUNTER SUPPLEMENTS*

Medication _____ Dose _____ For _____

Medication _____ Dose _____ For _____

Medication _____ Dose _____ For _____

Medication _____ Dose _____ For _____

Medication _____ Dose _____ For _____

Medication _____ Dose _____ For _____

LIST ANY ALLERGIES TO MEDICATIONS _____

SELECT ONE □ Never smoked □ Former smoker □ Current smoker, how much _____ pack / day

Family Physician _____ Date of last office visit _____

Previous Chiropractor(s) _____

OTHER SPECIALIST

Doctor _____ Treatment _____

Doctor _____ Treatment _____

Doctor _____ Treatment _____