**Welcome To**

**Full Life Chiropractic**

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Personal Data

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Date of Birth \_\_\_\_\_\_\_\_\_\_\_ Gender: M F

Home Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Cell Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_Work Phone(\_\_\_\_)\_\_\_\_\_\_\_\_\_**Circle your preferred phone number.**

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Marital Status: S M D W L/W Name of Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents’ names (if you are under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_

Business Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to Full Life Chiropractic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Reason for Seeking Chiropractic Care

What concerns do you feel Full Life Chiropractic can address for you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this concern affecting any of the activities below? (Please circle)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Work:** | Yes | No | **Recreation/play:** | Yes | No | **Sleep:** | Yes | No |
| **Social Life:** | Yes | No | **Walking:** | Yes | No | **Sitting:** | Yes | No |
| **Exercise:** | Yes | No | **Eating:** | Yes | No | **Love life:** | Yes | No |

# Other Data

Have you ever received Chiropractic care? Y N With Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why did you stop care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family medical doctor? Y N Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consult him/her regularly? Y N If so, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last medical consultation and result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Women: Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health, Wellness and Chiropractic Care**

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the PHYSICAL, CHEMICAL, or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. Please answer the following questions as accurately and completely as possible.

**History of Physical Stresses (Birth to Present)**

Birth Stress

Research indicates that the birth process can cause trauma to a baby’s spine and nerve system. Please indicate to the best of your recollection how you were birthed:

Was your birth: (check all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| drug induced | C section | breech | natural | forceps |
| prolonged | cord around neck | at home | in hospital | suction |

General Physical Trauma

Most trauma occurs in the early years (between birth and age 18-21). It is during those years that your spine and nerve system is growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (check all that apply and give dates)

Automobile (even as a passenger) motorcycle bicycle sports other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain how and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever injured your spine (neck, head, back, hips)? yes no

If yes, please explain how and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever broken any bones or sprained any part of your body? yes no

If yes, please explain how and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized? yes no

If yes, please explain how and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Chemical Stresses**

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed in the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Have you been vaccinated? | yes | no |  |  | | |
| Do you or have you ever taken? | prescription drugs | over the counter drugs | recreational drugs | | | |
| Have you been exposed to? | chemicals | fumes | dust | | smoke | |
| Do you consume? | alcohol | coffee/caffeine | tobacco | | |  |

List Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Medications Previously taken for more than 6 months?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Emotional Stresses**

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below. (Please circle)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Childhood trauma | Yes No | Loss of loved one | Yes No | Relationships | Yes No | Family | Yes No |
| Work or School | Yes No | Divorce/separation | Yes No | Financial | Yes No | Abuse | Yes No |
| Lifestyle change | Yes No | Parents’ divorce | Yes No | Illness | Yes No | Other | Yes No |

**Quality of Life**

|  |  |  |  |
| --- | --- | --- | --- |
| 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 |

**Financial Information**

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

**\*\*The cash fee for a new patient is $150.00, which includes the first consult, a chiropractic exam, a report of findings, and the first adjustment\*\***

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process, please fill out the “Insurance Permission” section below.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Permission**

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:

“I authorize Full Life Chiropractic to release to my insurance company any medical or other information necessary to process my insurance claims.”

“I authorize payment be made directly to Full Life Chiropractic. I permit a copy of this authorization to be used in place of the original.”

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also, if you are not the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Reminders and Health Care Information Authorization**

The following office procedures allow Full Life Chiropractic to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

* We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
* We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
* We routinely have mailings (including postcards) from our office sent to you at your home or email address.
* We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
* When you refer anyone to us, we would like to directly thank you and publicly thank you on the office bulletin board.
* We would like to be able to refer others to speak with you about your experience at Full Life Chiropractic.
* We often take and post photos of our practice members/patients in the office and in our newsletters.

**You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Full Life Chiropractic.**

**This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.**

We at Full Life Chiropractic are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Full Life Chiropractic’s *Notice of Privacy Practices for Protected Health Information.*Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

Patient name printed Date

Patient Signature CC representative

**Terms and Consent to Care**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the above (print name).

Outcomes and options relative to care have been discussed and noted. All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(signature) (date)

Electronic Health Records Intake Form

|  |  |
| --- | --- |
| **First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Mailing Address:**

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:**  \_\_/\_\_/\_\_\_\_ **Gender (Circle one):**  Male / Female **Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

|  |  |
| --- | --- |
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|  |  |
|  |  |
|  |  |

**Do you have any medication allergies?**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Reaction | Onset Date | Additional Comments |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

□ **I choose to decline receipt of my clinical summary after every visit.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Height: \_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure:\_\_\_\_\_\_ /\_\_\_\_\_\_ |

***Full Life Chiropractic***

**Name:**

**Last First Middle**

**ID# Date:**

**CREDIT CARD AUTHORIZATION**

**I, , give authorization for Full Life Chiropractic to charge my credit card in the amount of $ for any and all services rendered to me. I acknowledge that I am legally responsible for any and all charges and I authorize my credit card to be charged the total of any back balance if I decide to discontinue my care.**

**( ) Master Card ( ) Visa**

**Credit Card Number:**

**Expiration Date: Security Code(3 digits):**

**Address of Credit Card: Zip Code:**

**Signature: Date:**

**Our purpose is to educate and adjust families toward optimal health with natural chiropractic care**