Personal and Family Health History

Name ____
Date _________________
Address ______________________________________
City _____________________ State ____ Zip ________
Phone: (H) _______________ (W) ________________
E-mail ____
Date of Birth _______________ (Age ______)

Referred By ___________________________________
Social Security # ________________________________
Occupation ____________________________________
Employer _____________________________________
Marital Status S M D W
Spouse's Name ______________________________
Spouse's Occupation ___________________________

Number of Children and Ages / ***Previous Chiropractic Care?***

Name _____________________________ Age _____ Yes___ No___ Reason ______________________________
Name _____________________________ Age _____ Yes___ No___ Reason ______________________________
Name _____________________________ Age _____ Yes___ No___ Reason ______________________________
Name _____________________________ Age _____ Yes___ No___ Reason ______________________________

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

Circle all that Apply	*Patient*	*Spouse*	*Child#1*	*Child#2*	*Child #3*	*Chiropractor's Comments*
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_______________
Difficult Delivery?	Y	Y	Y	Y	Y	_______________
Forceps?	Y	Y	Y	Y	Y	_______________
Caesarian?	Y	Y	Y	Y	Y	_______________
Breach/cephalic?	Y	Y	Y	Y	Y	_______________
Home birth?	Y	Y	Y	Y	Y	_______________
Mother given drugs during delivery	Y	Y	Y	Y	Y	_______________
Induced Labor?	Y	Y	Y	Y	Y	_______________
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_______________
Fall out of bed?	Y	Y	Y	Y	Y	_______________
Bang your head?	Y	Y	Y	Y	Y	_______________
Breastfeed?	Y	Y	Y	Y	Y	_______________
Childhood sickness?	Y	Y	Y	Y	Y	_______________
Have any Accidents?	Y	Y	Y	Y	Y	_______________
Have Surgery?	Y	Y	Y	Y	Y	_______________
Take Drugs?	Y	Y	Y	Y	Y	_______________
Fall while learning to walk?	Y	Y	Y	Y	Y	_______________
Bullied by your siblings?	Y	Y	Y	Y	Y	_______________
Child abuse	Y	Y	Y	Y	Y	_______________
Spanking?	Y	Y	Y	Y	Y	_______________
Pulled ear/chin	Y	Y	Y	Y	Y	_______________
Other	Y	Y	Y	Y	Y	_______________
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_______________
Fall down the stairs?	Y	Y	Y	Y	Y	_______________
Pulled by your arm?	Y	Y	Y	Y	Y	_______________
Experience other traumas?	Y	Y	Y	Y	Y	_______________
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	_______________
Drink	Y	Y	Y	Y	Y	_______________
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_______________
Have you been in accidents?	Y	Y	Y	Y	Y	_______________
Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	_______________

© 2016 The Family Practice, Inc. All Rights Reserved.

Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	______________
Have Teeth Problems?	Y	Y	Y	Y	Y	______________
Have Eye Problems?	Y	Y	Y	Y	Y	______________
Have Hearing Problems?	Y	Y	Y	Y	Y	______________
Exercise regularly?	Y	Y	Y	Y	Y	______________
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	______________
Have occupational stress?	Y	Y	Y	Y	Y	______________
Have physical stress?	Y	Y	Y	Y	Y	______________
Have mental stress?	Y	Y	Y	Y	Y	______________
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	______________
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	______________

Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?
Major ____
Pain or Problem started on____
Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent
What activities aggravate your condition/pain? ______________________________________
What activities lessen your condition/pain? ____
Is condition worse during certain times of the day? ___________________________________
Is this condition interfering with work? ______ Sleep? ______ Routine? ______ Other? _______
Is this condition getting progressively worse? _______________________________________
Other Doctors seen for this condition ____
Any home remedies? ____

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Stomach Upset
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Constipation
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in Ear
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Fatigue	❒ Loss of Taste	
❒ Dizziness	❒ Depression	❒ Diarrhea	

Have you been under drug and medical care? ____
What medications are you taking? ____
How Long? _________________ Have you had surgery? ________________ What? ________ When?__________
What side effects have you experienced from the drugs and surgery? ______________________________

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _______________
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Your oldest grandparent on record lived to the age of ________.
❒ Still living ❒ Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

❒ Feel better quickly
❒ Live a healthier lifestyle
❒ Have a healthier spine and nervous system

____ Signature

____________________ Date

© 2016 The Family Practice, Inc. All Rights Reserved.

TERMS OF ACCEPTANCE

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.

Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

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.

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. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________ have read and fully understand the above statements.
(print name)

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)

© 2016 The Family Practice, Inc. All Rights Reserved.

Office Fee Schedule and Financial Policy

Service	Regular Fees	Procedure Codes	CHUSA Fees
Consultation	**$95** ***Waived if you proceed with an exam**		**$95** ***Waived if you proceed with an exam**
NP Exam Basic NP Exam Intermediate NP Exam Comprehensive	**$150** **$225** **$340**	**99202** **99203** **99204**	**$125**
Established Patient Re-Exam	**$115**	**99212**	**$105**
Adjustment Manual Therapy Radiologic Exam	**1-2 regions $60** **3-4 regions $80** **5+ regions $105** **ArthroStim $55** **$200** **Per View $40**	**98940** **98941** **98942** **97140**	**$55** ***Includes manual therapy if performed** **$150** **Per View $30**
Student/Children Adjustment (17 and under)	**Regular fees as stated above**		**CHUSA only $35**

Financial Policy and Active Life Plans

We are committed to providing you with the best chiropractic care in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Adjustment Plan in advance. These plans are designed to be the most cost-effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition and Lifestyle Care Options. Details of these plans will be discussed with you during your Chiropractic Report.

☐ **Insurance Reimbursement**

Our office does not file major medical insurance. Should you choose to utilize your insurance, we will provide receipts for your submission to your respective insurance company. These services will be billed at the regular fee as stated above. We can also provide receipts for your submission to personal and company health accounts. These receipts will be emailed to you monthly.

☐ **CHUSA Network Members**

We are a participating provider of ChiroHealth USA, a third-party membership program that provides you and your family access to the discounted fees in the right column above for an annual family fee of $49.

I, (name) ___________________________________ have read the above policies and checked the one that applies to me.

Patient signature__________________________________Date_____/______/__________

ChiroHealthUSA
The Network That Works for Chiropractic!

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR ENROLLMENT AND MEMBERSHIP IN THE CHIROHEALTHUSA NETWORK

I,__________________________, authorize my provider,_______________________, to use and disclose my health information (including my name, phone number, address, email address, date of birth, gender, dependents name, name of my provider, and payment information) to ChiroHealthUSA for purposes of enrolling me in the ChiroHealthUSA network, and to send me marketing materials and other communications related to my ChiroHealthUSA network membership. I understand that my provider will not receive direct or indirect remuneration from ChiroHealthUSA in connection with this use and disclosure of my health information.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") and various state laws govern the terms of this Authorization. I understand this Authorization is limited to only the health information described above, and does not apply to sensitive categories of information (such as psychotherapy notes, genetic, mental health, substance abuse, or HIV/AIDS information).

I understand that I may revoke this Authorization at any time by contacting my provider and/or ChiroHealthUSA in writing at 250 Katherine Dr., Flowood, MS 39232, 888-719-9990. My revocation will be effective upon my provider and/or ChiroHealthUSA's receipt of such revocation, but will not be effective to the extent that they have already acted in reliance upon my prior Authorization.

I understand that my provider may not condition treatment or payment, or eligibility for benefits or enrollment in a health plan, on my signing of this Authorization. I understand that my health information disclosed pursuant to this Authorization may be further used and disclosed by ChiroHealthUSA to communicate with me regarding my ChiroHealthUSA membership, and no longer protected by HIPAA. I understand that I have a right to receive a copy of this Authorization.

This Authorization shall expire in accordance with the below, unless earlier revoked by me by notifying my provider and/or ChiroHealthUSA using the contact information and in the manner described above (check the applicable box):

- ☐ **Maryland**: One year from the date of signing this authorization
- ☐ **Maine**: 30 months from the date of signing this authorization
- ☐ **California**: On the________day of_____________, _______
- ☐ **All other states**: When my membership expires

____ _________________________

Signature of Patient or Personal Representative Date of Signature

______________________ ____

Relationship to Patient Patient Address