FAMILY FIRST CHIROPRACTIC & WELLNESS
HEALTH HISTORY FORM

PERSONAL DATA

Today's Date_____

Name_____ Age _____ Date of Birth _____

Parent's names (if you are under 18) _____

Home Address_____ City _____ State_____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____E-mail address_____

Occupation_____Employer _____

Business Address_____ City_____State_____ Zip _____

SS# (opt'l)_____ Emergency contact _____

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partner _____

Names and Ages of Children _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

How do you think we may be able to help you? _____

_____

Are these concerns affecting your activities of daily living? (Please circle Y for those that apply to you)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

CHIROPRACTIC CARE HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C._____

How long under care? ❑ _____days ❑_____weeks ❑_____ months ❑ years_____

Date of last visit: _____ Are you currently under chiropractic care or did you stop? _____

If you stopped chiropractic care, why?_____

Have you consulted or do you regularly consult any of the following providers? (Check all that apply.)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason why: _____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: _____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to and how they may relate to your current health status.

PHYSICAL STRESS

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your **childhood up to the present**.

Have you had any accidents or injuries in your life related to any of the following? (Check all that apply.)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If you have check any of the above, please state the ***type of injury and date:***

_____

_____

Have you ever hurt, broken, fractured or sprained any bones or joints? ❑ Y ❑ N

If yes, list body parts injured and dates if not already listed above***:***__

_____

Have you ever been hospitalized? ❑ Y ❑ N

If yes, tell us the dates and reasons if not alreay listed above***:***_____

_____

Do you or have you ever played a sport or had a job that required you to use a repetative motion on the same joint, muscle, ligament, and tendon? ❑ Y ❑ N If yes, what sport or job_____

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated?** ❑ Y ❑ N If yes, did you have a **reaction**? ❑ Y ❑ N

Have you been **exposed to** any of the following on a regular basis, (past or present)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

Do you have **allergies** to any foods? ❑ Y ❑ N **If yes, please list:** _____
_____

Do you **consume** any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____
_____

EMOTIONAL STRESS

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

Work	Y	N	Financial	Y	N	Illness	Y	N
School	Y	N	Divorce/Separation	Y	N	Abuse	Y	N
Moving	Y	N	Parents Divorce	Y	N	Loss of Loved One/Friend	Y	N
Lifestyle	Y	N	Childhood Trauma	Y	N	Change of Employment	Y	N

If you want to share, please feel free to elaborate on any emotional stresses you listed on the previous page you think may be contributing to your overall health status. _____
_____

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

Do you **exercise** regularly? If yes, how often? _____

_____

Do you take **supplements**? If yes, please list:_____

_____

Do you follow a **special dietary regime**? If yes, what? _____

_____

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Relief and prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels

YOUR INFORMED CONSENT

The information I have provided on this case history form, is true and accurate to the best of my knowledge. Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know: 1. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported; 2. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause. Chiropractic care has been proven to be both, clinically and cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I have been informed and fully understand that Chiropractic care is not a treatment of any disease or condition. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for me and my family.

Signature _____ Date _____

Signature of Parent (for Minor) _____ Date _____

FINANCIAL RESPONSIBILITY

Family First Chiropractic & Wellness

In return for services rendered to me by Family First Chiropractic & Wellness, I promise to pay in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment for any reason.

Assignment of Benefits – I understand that Family First Chiropractic and Wellness Center is not a provider for my insurance company or any insurance company. I understand that benefits I may try to claim form my insurance company for services rendered at this Wellness Center quoted from my insurance carrier are only an estimate and not a guarantee of payment.

Medicare – I acknowledge that Family First Chiropractic & Wellness is NOT a Medicare Provider and DOES NOT accept Medicare Benefits.

Release of Medical Information and Records
By signing below I authorize Family First Chiropractic & Wellness to release all medical information and/or records requested by my insurance company or any referring doctor. By signing below I also authorize Family First Chiropractic & Wellness to use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided and any administrative operations related to treatment or payment.

Acknowledgment of Privacy Practices
I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Family First Chiropractic & Wellness, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary.

_____ _____

Signature of Patient (or legal Guardian) Date