Fort Valley
FAMILY CHIROPRACTIC

ADULT PATIENT

CONFIDENTIAL HEALTH HISTORY

Name (Last)_____ (First)_____ (Middle)_____ Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital Status: S M D W Sex: M F Spouse's Name _____

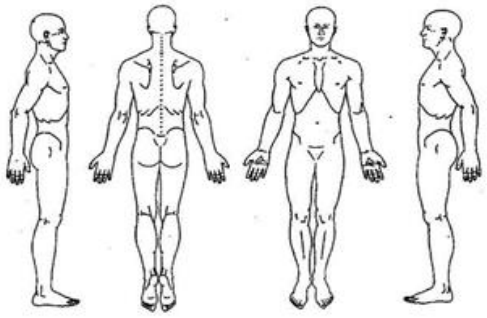
Home # (____) _____ Work # (_____) _____ Cell # (_____) _____ E Mail _____

Emergency Contact Name_____ Phone _____ Relationship _____

Insurance Co.	_____	Group#	_____	ID #	_____
Name of Insured	_____	Birth Date	_____	SS #	_____
Insured's Employer	_____			Work #	(_____)_____
Relation to Insured	_____	Referred by	_____		

REASON FOR CONSULTING OUR OFFICE

Please outline and shade where you have pain or other symptoms



When did your symptoms start? _____

How did your symptoms begin? _____

_____

1. PRIMARY COMPLAINT:

(Choose ONLY ONE)

___	Head	___L ___R	Shoulder
___	Neck	___L ___R	Elbow
___	Upper Back	___L ___R	Arm/Hand
___	Mid Back	___L ___R	Hip
___	Lower Back	___L ___R	Knee
___	Pelvis	___L ___R	Leg/Foot

Pain Intensity:

0 1 2 3 4 5 6 7 8 9 10

How Often?	**(% of the day):**
___ Constant	(76-100%)
___ Frequent	(51-75%)
___ Intermittent	(26-50%)
___ Occasional	(0-25%)

Describe Your Symptoms:

___ Sharp ___ Stabbing

___ Dull ___ Burning

___ Numbness/Tingling ___ Aching

What makes your symptoms worse?

___ Standing ___ Walking ___ Sitting

___ Laying ___ Coughing ___ Lifting

What makes your symptoms better?

___ Resting ___ Ice ___ Heat

___ Activity ___ Medicine _____

Condition feels better in the:

___ Morning ___ Afternoon ___ Evening

Condition feels worse in the:

___ Morning ___ Afternoon _ Evening

2. SECONDARY COMPLAINT:

(Choose ONLY ONE)

___	Head	___L ___R	Shoulder
___	Neck	___L ___R	Elbow
___	Upper Back	___L ___R	Arm/Hand
___	Mid Back	___L ___R	Hip
___	Lower Back	___L ___R	Knee
___	Pelvis	___L ___R	Leg/Foot

Pain Intensity:

0 1 2 3 4 5 6 7 8 9 10

How Often?	**(% of the day):**
___ Constant	(76-100%)
___ Frequent	(51-75%)
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___ Occasional	(0-25%)

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What makes your symptoms better?

___ Resting ___ Ice ___ Heat

___ Activity ___ Medicine _____

Condition feels better in the:

___ Morning ___ Afternoon ___ Evening

Condition feels worse in the:

___ Morning ___ Afternoon _ Evening

3. ADDITIONAL COMPLAINTS:

___	Head	___L ___R	Shoulder
___	Neck	___L ___R	Elbow
___	Upper Back	___L ___R	Arm/Hand
___	Mid Back	___L ___R	Hip
___	Lower Back	___L ___R	Knee
___	Pelvis	___L ___R	Leg/Foot

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Your current history:

General:	__ Fatigue	__ Weakness	__ Fever / Chills	__ Weight Change	__ Night Sweats
Skin:	__ Pain	__ Rash	__ Redness	__ Itching	__ Eczema
Eyes:	__ Pain	__ Discharge	__ Infection	__ Vision Trouble	
Ears:	__ Pain	__ Discharge	__ Infection	__ Hearing Trouble	__ Ringing
Nose:	__ Pain	__ Bleeding	__ Infection	__ Absence of smell	__ Obstruction
Mouth/Throat:	__ Pain	__ Bleeding	__ Gum Disease	__ Abnormal Taste	__ Lesions
Heart:	__ Pain	__ Palpitations	__ Edema/ Swelling	__ Murmur	__ Fainting
Lungs:	__ Pain	__ Cough	__ Phlegm	__ Difficult breathing	__ Bloody Discharge
Gastrointestinal:	__ Pain	__ Nausea	__ Diarrhea	__ Constipation	__ Weight Change
Genitourinary:	__ Pain	__ Discharge	__ Blood in Urine	__ Incontinence	__ Frequent Urination
	__ Sterility	__ Impotence	__ Abnormal Bleeding	__ Amenorrhea	
Endocrine	__ Hair Loss	__ Thirsty	__ Tremors	__ Hot/cold intolerance	__ Sleep issues
Neurological:	__ Headaches	__ Seizures	__ Dizziness	__ Numbness	

Your Past History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Family History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems

Current Medications:	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Your Social History:	__ Never Smoked	__ Former Smoker	__ Current Smoker
	__ No Alcohol	__ Drink Alcohol	__ No Recreational Drugs
Allergies:	__ Sinus / Respiratory	__ Food / Digestion	__ Skin
	__ Prescription Medicine (Names Allergic To)_____		
Surgeries:	Type/area_____When?_____		
	Type/area_____When?_____		
	Type/area_____When?_____		

Activity Level: __ Sedentary __ Light physical Activity __ Moderate Physical Activity __ Intense Physical Activity

ADULT PATIENT

CONFIDENTIAL HEALTH HISTORY

Have you had Chiropractic care before? ___ No ___ Yes When? _____

For Females Only:

To your knowledge, are you pregnant? ___ No ___ Yes

Are you taking birth control medicines? ___ No ___ Yes Name_____

Are you seeing an OB-GYN doctor regularly? ___ No ___ Yes

DISCLOSURE & INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare you or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments to me, by Dr. Nadia M. Ramirez or any other licensed Doctors of Chiropractic working at the office serving as a backup for the regular attending Doctors of Chiropractic.

I have had the opportunity to discuss with the attending Doctor of Chiropractic, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Print Name _____

ADULT PATIENT

CONFIDENTIAL HEALTH HISTORY

PRIVACY NOTICE

We want you to know how your **Patient Health Information (PHI)** will be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your **PHI,** we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Fort Valley Family Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care options, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given the request has been presented.
5. For your security and right to privacy, the staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Fort Valley Family Chiropractic to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.
8. The patient understands and consents to the following appointment reminders or communications that will be used by Fort Valley Family Chiropractic:
    a. Cards or postcards mailed to the patient at their address provided by them; and
    b. Telephone calls to the patient's home, work and/or cell phone, leaving a message on their answering machine, voice mail, or with the individual answering the phone if the patient is not available at the time of the call; and
    c. The sign-in sheet located at the reception desk in which the patient is required to sign upon entering the office.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I clearly understand and agree that all services rendered me and charged to me are my responsibility to be paid to the doctor. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. This consent will end when my current treatment plan is completed or one year from the date signed below.

I HAVE READ AND UNDERSTAND THE FOREGOING NOTICE, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

Patient Signature _____ Date: _____

Print Name _____

Signature of Patient Representative _____ Date: _____

Print Name _____ Relationship to patient _____