Carter Family Chiropractic

File #__________________

Patient Information Form

Name____ Date____________________
Address____________________________________ City__________________ State______ Zip__________
Home Phone (   ) _______________ Work Phone (   ) ______________ Cell Phone (   ) ___________________
Email Address____
How do you prefer to be contacted? □ Mail □ Home Phone □ Cell Phone (Carrier____________) □ Email
What time do you prefer? □ AM □ PM

Who do we thank for referring you to us? ____

Gender: □ Male □ Female Date of Birth____/____/_____ Age_____
Social Security #________-______-__________

Parent's/Guardian Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered
Has your child ever received Chiropractic Care? □ Yes □ No If yes, when, where, & why? ____________________
Emergency Contact Name ______________________________ Emergency Contact Number (   ) ______________

Insurance Information

Name of Insured____________________________ Relationship to patient______________________
Insured's Social Security #______-_______-_______ Date of Birth______________________________
Insurance Company___________________________ Insurance Phone (   ) ____________________
ID #______________________________________ Group #____________________________________

Certification and Assignment

- To the best of my knowledge, the above information is complete and correct. I understand this is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
- I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to Carter Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
- I understand that I will be charged $25.00 for a missed appointment if I do not notify the office via phone or email at least 8 hours or earlier to the committed time schedule.

The above named doctor may use my health care information and may disclose such information to the above name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

____ ____________________
Signature of Patient Date

____ ____________________
Please print name of Patient Date

Carter Family Chiropractic

Patient Name: ____________________________________

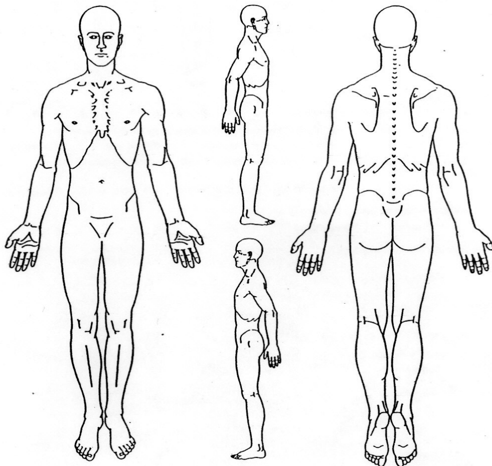
Date:______________________ **File #:** ____________

Personal Health History

Reason for today's visit: ☐ New Injury ☐ Chronic Pain ☐ Old Injury ☐ Wellness Visit
Did your injury occur during: ☐ Work ☐ Sleep ☐ Sports/Play ☐ Auto Accident ☐ Routine/Household Activity
CHIEF SUBJECTIVE COMPLAINT: (briefly describe) ____
____
When did your condition/accident occur? ____/____/____ **Where did your injury occur?**________________
Is your condition getting worse? ☐ Yes ☐ No ☐ Comes and Goes
Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
If so, how?: ____
Has this or something similar happened in the past? ☐ Yes ☐ No
What have you been told is wrong? ____

Using the body chart below, please circle all affected areas:

Circle the symbols to best describe the type(s) of pain:
D = Dull Ache N = Numbness B = Burning
S = Sharp T = Tingling (pins & needles)



Are you in pain? ☐Yes ☐ No
Circle your pain on the following scale for each area of your body:

	(no pain)										(unbearable)
Neck	0	1	2	3	4	5	6	7	8	9	10
Middle Back Pain	0	1	2	3	4	5	6	7	8	9	10
Lower Back Pain	0	1	2	3	4	5	6	7	8	9	10
Other: ___________	0	1	2	3	4	5	6	7	8	9	10

Has your child been treated by a medical physician for this pain?
☐ **Yes** ☐ **No**
If Yes, where & when: ________________________________

Has your child ever been treated by a chiropractor?
☐ **Yes** ☐ **No**
If yes, where & when: ________________________________

Are your children taking any of the following medications?
☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers
☐ Ritalin ☐ Tranquilizers ☐ Insulin
☐ Anti-Depressants ☐ Steroids ☐ Other____________________

Frequency of Pain:
☐ Constantly (76%-100% of the day)
☐ Frequently (51%-75% of the day)
☐ Occasionally (26%-50% of the day)
☐ Intermittently (0%-25% of the day)

Pain Better:
☐ AM ☐ At Rest
☐ Mid-Day ☐ Does Not Change
☐ PM ☐ Other

Pain Worse:
☐ AM ☐ At Rest
☐ Mid-Day ☐ Does Not Change
☐ PM ☐ Other

Do you or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Heart Surgery/Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol/Drug abuse	Y N Venereal Disease	Y N Hepatitis	Y N Anemia/Diabetes
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Kidney Problem
Y N High Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Artificial Bones/Joints	Y N Tuberculosis
Y N Ulcers/Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema/Asthma	Y N Arthritis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower back Problems	Y N Severe/Frequent Headaches	

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File #: _____________

<u>Child's Birth History</u> – Please check those items that apply to your child

□ Mother smoked/drank/drugs in pregnancy
□ Breech Delivery
□ C-Section Delivery
□ Complications
□ Very Short Labor
□ Epidural/Meds in labor
□ Forceps/ Vacuum Extractor Delivery
□ Premature/Overdue
□ Labor Induced
□ Very Long Labor
□ Other_______________________

Is there anything else you would like us to know about your child's health?
Was your child vaccinated? □ Yes □ No
If yes, did you opt out of any specific immunization? □ Yes □ No
If yes, what immunization and why? ____
Allergies: ____
Fractures, concussions, other injuries:
____
Surgeries: ____
Auto accidents: ____
List any medications/supplements: ____
Briefly describe child's diet: ____

- **To the best of my knowledge, the above information is complete and correct. I understand this is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.**

____ ________________________
Signature of Patient, Parent, Guardian **Date**

____ ________________________
Signature of Doctor **Date**

File #: ___________

Terms of Acceptance

When a person seeks Chiropractic care and we accept a person 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 person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment Process: A series of specific force applications to facilitate the body's connection between itself and the intelligence that continually maintains it in existence. Our chiropractic method of connection is by specific adjustments of the spine.

Health: Also known as ease, this is the bodies ability to overcome everyday stresses and continually grow through adaptation.

Vertebral Subluxation Process: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

Open Adjusting: We use open bay areas for routine adjustment and therapy visits. If you require a private area, one will be provided upon request.

We do not offer to diagnose or treat any disease. Our focus in this office is the body's fullest expression of LIFE and the roles that the vertebral subluxation process will/can have upon it. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

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 locate and analyze the vertebral subluxation process and the administration of the specific adjustment process to allow the free flow of innate intelligence throughout your body.

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

All questions regarding the chiropractors' objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature____Date__________________________

CONSENT TO EVALUATE AND ADJUST A MINOR

I,________________________________being the parent or legal guardian of ________________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature____Date____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. Date of last menstrual period:____________________________

Signature____Date____

File #: __________

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Carter Family Chiropractic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.
I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Carter Family Chiropractic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________________ ____________________________________

Signature of Patient or Personal Representative Printed Name of Patient

____

Date of Signing