PATIENT INFORMATION

Full Health History

NAME (FULL FORMAL):_____(PREFERRED TO BE CALLED: _____)

ADDRESS:_____

CITY: _____ STATE: _____ZIP:_____+_____

PHONE# (_____) _____ **CIRCLE: CELL / HOME** EMAIL:_____

Communication Consent - Circle one: Text / Email / Both / None for appointment reminders, etc.

DATE OF BIRTH: _____ AGE: _____ GENDER: MALE / FEMALE MARITAL STATUS: S / M / D / W

SSN: _____ EMPOYER /JOB:_____

HOW DID YOU HEAR ABOUT OUR OFFICE/WHOM MAY WE THANK: _____

ARE WE FILING INSURANCE? NO / YES → Is your insurance a MEDICARE TYPE: NO /YES → plus supplement: NO / YES

Please provide all insurance cards and a photo ID to the front desk.

CONSENTS / ACKNOWLEDGEMENTS

- I understand that most care is given in an open adjustment office setting.
- I consent to receive communication from the office in connection with my care via postal mail, email, text, & telephone messaging. ** If I withdraw my consent, I will notify the office in writing.*
- A copy of the privacy policies is always available at the front desk.
- This initial visit includes a health history consultation, chiropractic exam and evaluation followed by any initial care that is determined to be clinically necessary and mutually agreed upon.
- I do give the doctors at Family Chiropractic of Chattanooga permission to render care to me today.
- I agree that I am responsible for paying for all services I receive in this office, at the time of service.
- I assign this office the right to collect payments from all third-party payers, such as my insurance.
- I authorize the release of my medical or other information necessary to process claims.
- Emergency/Weekend/After-hours appointments will be charged $75.00 cash/check only (not billed to insurance)
- ****The doctor's phone number listed on our OGM is for emergency use only; DO NOT text/call during office hours.***
- *****Missed/cancelled appointments, without 24 hr. notice, may be charged $15.00***
- *****PAYMENT: CASH, CHECK, or CREDIT/DEBIT [cards kept on file will be used to pay your balances due]**

My signature below signifies the above demographic information given by me is correct to the best of my knowledge, and the consents/acknowledgements have been read, understood, and agreed upon.

PATIENT'S SIGNATURE: _____DATE: _____

* LEGAL GUARDIAN'S SIGNATURE: _____ DATE: _____

Family Chiropractic of Chattanooga, Inc.
6341 East Brainerd Road
Chattanooga, TN 37421
Tel (423) 355-KIDS (5437)

HEALTH HISTORY

Print Name: _____ **Date of birth:** _____

TOP 3 CONCERNS FOR SEEKING CHIROPRACTIC CARE & THEIR RELATED PAIN SCALE (NONE) 0 – 10 (SEVERE)

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10

ARE YOUR CONCERNS AFFECTING YOUR QUALITY OF DAILY LIFE ACTIVITIES?

Work Y / N School Y / N Walking Y / N Driving Y / N Posture Y / N

Sleeping Y / N Exercise Y / N Sitting Y / N Eating Y / N Sports Y / N

Love Life Y / N Other _____

HAVE YOU CONSULTED, OR DO YOU REGULARLY CONSULT: (Circle ALL that apply)

Medical Physician Naturopath Acupuncturist Homeopath Chiropractor

Massage Therapist Podiatrist Physical Therapist Orthopedist Dentist

PAST SURGICAL HISTORY (Circle all that apply)

Appendectomy Angioplasty Arthroscopic Bladder Biopsy Endoscopy Fracture Gall Bladder Heart bypass

Hysterectomy Kidney stone Pacemaker Spine/back Spinal fusion Thyroidectomy Tonsillectomy Total joint

OTHER: _____

PAST MEDICAL HISTORY (Circle all that apply)

Allergies Alcoholism Anemia Arthritis Asthma Cancer Colitis Diabetes Digestive Disorder

Dizziness/Vertigo Emphysema Endometriosis Epilepsy Fibromyalgia Goiter Gout Heart Trouble

Herpes Hernia High BP High Cholesterol Leukemia Lupus Migraines/HA MVP Mental Condition

Menopause Nervous/Anxiety Obesity Sleeplessness Staph/MRSA Stress Stroke Tuberculosis Ulcers

OTHER: _____

FAMILY HEALTH HISTORY: _____

_____

WOMEN ONLY SECTION:

Pregnant? YES / NO / UNKNOWN Last menstruation date: _____ Due Date: _____

# of births _____; # of C-Sections _____; # of miscarriages _____; breast augmentation: reduce / enlarge / mastectomy

PHYSICAL STRESS: (Major traumas from childhood through adult)

Circle all that apply =	Automobile	Motorcycle	Bicycle	Sports	Playground	OTHER
Date of occurrence =	_____	_____	_____	_____	_____	_____

Injuries to body (include broken, fractured, sprained, or painful bones/joints of head, spine, ribs, chest, pelvis/hips, legs/arms)

_____

_____

HEALTH HISTORY (cont.)

Print Name: _____ **Date of birth:** _____

EMOTIONAL STRESS: (childhood through adult)

Childhood Trauma Y / N	Loss of Loved one Y / N	Abuse Y / N
Work or School Y / N	Divorce / separation Y / N	Financial Y / N
Lifestyle change Y / N	Parents Divorce Y / N	Illness Y / N

CHEMICAL STRESS: (childhood through adult)

Vaccinations Y / N -- vaccine reaction Y / N / unsure

Sensitivities / Allergies -- to what : _____

If consume, circle all that apply -- Caffeine / Tobacco / Alcohol / Rx Drugs / OTC Drugs / Sugar / Dairy

Past or present, regular exposure to: Smoke / Toxic chemicals / Radiation / Drug Therapy / Chemotherapy

Current medications (Rx or OTC) & supplements: _____

_____

DO YOU HAVE ANY OF THESE SYMPTOMS *CURRENTLY OR CHRONICALLY?*

→ **CIRCLE : 0 = N/A 1 = MILD / RARE 2 = MODERATE / OCCASIONAL 3 = SEVERE /CONSTANT**

GENERAL HEALTH

0 1 2 3	Fatigue / Tiredness
0 1 2 3	Fever / Night Sweats
0 1 2 3	Trouble Sleeping
0 1 2 3	Skin Irritations / Rashes / Hives
0 1 2 3	Bleeding Disorders
0 1 2 3	Depression
0 1 2 3	Anxiety / Tension / Stress

EYE, EAR, NOSE, THROAT

0 1 2 3	Vision / Eye Problems
0 1 2 3	Hearing / Ear Problems
0 1 2 3	Throat / Voice / Swallow Problems
0 1 2 3	Nasal /Sinus Problems
0 1 2 3	Headaches / Face Pain

GASTROINTESTINAL

0 1 2 3	Mouth / Stomach Ulcers
0 1 2 3	Stomach / Abdominal Pair
0 1 2 3	Diarrhea / Constipation
0 1 2 3	Vomiting / Nausea
0 1 2 3	Reflux / Indigestion

GENITOURINARY

0 1 2 3	Urinary Frequency / Urgency
0 1 2 3	Urinary Burn /Pain/ Discoloration
0 1 2 3	Sexual / Reproductive Problems

CARDIOPULMONARY

0 1 2 3	Breathing Problems
0 1 2 3	Swelling / Edema
0 1 2 3	Chest Pains

SKELETAL

0 1 2 3	Morning Stiffness
0 1 2 3	Night Pain
0 1 2 3	Neck Pain
0 1 2 3	Shoulder / Arm / Wrist / Hand Pain (left / right)
0 1 2 3	Hip / Leg / Knee / Ankle / Foot Pain (left / right)
0 1 2 3	Mid-Back / Low Back Pain

NEUROMUSCULAR

0 1 2 3	Muscle Pain
0 1 2 3	Muscle Weakness
0 1 2 3	Numbness / Tingling
0 1 2 3	Tremors / Shakes
0 1 2 3	Loss of Consciousness / Passing out

HEALTH HISTORY (cont.)

Print Name: _____ **Date of birth:** _____

Additional Symptoms or health concerns you would like to address:

_____

_____

_____

QUALITY OF LIFE (PRESENTLY)

- 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 follow a special dietary regime? _____

**** I give FCOC, Inc. consent to discuss my medical issues/chart details with specific individuals listed below:**
[for example: emergency contact, spouse, children, parent, or any other designated individuals]

Name	Relationship	Contact#

List any restrictions or other details you would like us to know about in reference to discussing your chart:

_____

_____

_____

My signature below is my agreement that all the health history information provided, on the last three pages of this form, is true to the best of my knowledge.

_____ /_____

Patient Signature / Today's Date

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