PATIENT INFORMATION

Full Health History

NAME (FULL FORMAL):______________________________________(PREFERRED NAME: ______________________)

ADDRESS:____

CITY: ____ STATE: _______ ZIP: _____________+_________

PHONE# (______)_______________________ CIRCLE: CELL / HOME (if cell, we send appt reminders; you may opt out)

EMAIL:____

EMERGENCY CONTACT- Name:_______________________________#(______)_________________________

DATE OF BIRTH: ______________________ AGE: _____ GENDER: MALE / FEMALE

SSN: ____ MARITAL STATUS: S / M / D / W

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____

ARE WE FILING INSURANCE? NO / YES -name of primary insurance company? ________________________________

➔ If YES: CIRCLE →(COMMERCIAL) or (MEDICARE TYPE) → (WITH SUPPLEMENT) or (WITHOUT SUPPLEMENT)

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.
- The information I have provided on this case history form is true and accurate to the best of my knowledge.
- I 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.
- If this account is placed with attorney or collections, I am responsible for all fees.
- I assign this office the rights 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.
- The office will not enter a dispute with your insurance company; we will provide you with information needed
- Emergency/Weekend/After-hours appointments will be charged $75.00 cash/check only (not billed to insurance)
- ***Missed appointments, without notice/communication, may be charged $15.00***
- ****PAYMENT: CASH, CHECK, or CREDIT/DEBIT [cards kept on file will be used to pay your balances due]**

Please provide your photo id along with any available insurance information before seeing the doctor today.

PATIENT'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)

	Automobile	Motorcycle	Bicycle	Sports	Playground	OTHER
Circle all that apply = / 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 THESE SYMPTOMS *CURRENTLY OR CHRONICALLY*?

→ CIRCLE THE NUMBER THAT BEST DESCRIBES – *LEAVE BLANK IF DOES NOT APPLY*

1 = MILD / RARE 2 = MODERATE / OCCASIONAL 3 = SEVERE / CONSTANT

GENERAL HEALTH

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

EYE, EAR, NOSE, THROAT

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

GASTROINTESTINAL

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

GENITOURINARY

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

CARDIOPULMONARY

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

SKELETAL

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

NEUROMUSCULAR

1 2 3	Muscle Pain
1 2 3	Muscle Weakness
1 2 3	Numbness / Tingling
1 2 3	Tremors / Shakes
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:**

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 information provided on this form is true to the best of my knowledge.

________________________________/________________________

Patient Signature / Today's Date

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