

PATIENT INFORMATION

Full Health History

NAME (FULL FORMAL): _____ (PREFERRED NAME: _____)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ + _____

CELL# _____ HOME# _____

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 FOR YOU? NO / YES – AETNA / BCBS / CIGNA / HUMANA / UHC / OTHER: _____

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, may be charged \$15.00**
- ***PAYMENT: CASH, CHECK, or CREDIT [credit 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)

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? [Do not circle if symptom is not present CURRENTLY OR CHRONICALLY]

---> CIRCLE THE NUMBER THAT BEST DESCRIBES THEM **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? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

- Relief of a symptom or problem Y / N
- Relief AND Prevention of a symptom or problem Y / N
- Healthier spine and nerve system Y / N
- Optimal health on all levels Y / N

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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life@fcochat.com

