Forbes Chiropractic
Case History

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

H. Phone (____) _____ Cell Phone (____) _____ Date of Birth _____ (Age _____)

Occupation _____ Employer _____

Marital Status S M D W Gender M☐ F☐ Spouses Name _____

Spouses Occupation _____ Number of Children & Ages _____

Have you ever received Chiropractic Care Y☐ N☐ Language Preference _____

Email _____ Referred by _____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes	No		Patient Comments if answer is Yes
		1. Birth Process	
☐	☐	Home birth?	_____
☐	☐	Hospital birth?	_____
☐	☐	Was mother given drugs during delivery?	_____
☐	☐	Was labor induced?	_____
☐	☐	Caesarean?	_____
☐	☐	Were used Forceps?	_____
☐	☐	Breach/cephalic? fetus's buttocks, feet, or both are in place to come out first during birth.	_____
		2. Growth and Development	
☐	☐	Were you breast fed?	_____
☐	☐	Childhood sicknesses?	_____
☐	☐	Accidents?	_____
☐	☐	Surgery?	_____
☐	☐	Drugs?prescriptive or non-prescriptive?	_____
☐	☐	Were you picked on by siblings?	_____
☐	☐	Child abuse?	_____
☐	☐	Spanking?	_____
☐	☐	Pulled ear/chin?	_____
☐	☐	Were you yanked by your arm?	_____
☐	☐	Did you have other traumas or Accidents? What? When?	_____

Yes	No	3. Current Health Habits	Patient Comments if answer is Yes
□	□	Did/ Do you smoke?	_____
□	□	Did/ Do you drink Alcohol?	_____
□	□	Do you eat healthy foods?	_____
□	□	Ears, eyes, Nose or Teeth Problems?	_____
□	□	Hearing problems?	_____
□	□	Sleeping habits (any Nightmares ?)	_____
□	□	Sleeping Posture? □ Side □ Stomach □ Back?	_____
□	□	Did/ Do you have occupational stress?	_____
□	□	Physical Stress?	_____
□	□	Mental/ Emotional Stress?	_____
□	□	Hobbies/ Sports injuries?	_____

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years continuing damage showed up as acute or chronic symptoms.

Present Complaint (be brief)
Major _____
Pain or Problem started on _____
Pains are: □ Sharp □ Dull □ Constant □ Intermittent
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Is condition getting progressively worse? _____
Other Doctors seen for this condition _____
Any home remedies? _____

Other symptoms:

□ Headaches	□ Pins & Needles in Legs	□ Fainting	□ Feet Cold
□ Neck Pain/Stiffness	□ Pins & Needles in Arms	□ Loss of Smell	□ Hands Cold
□ Sleeping Problems	□ Numbness in Fingers	□ Loss of Taste	□ Stomach Upset
□ Back Pain	□ Numbness in Toes	□ Diarrhea	□ Constipation
□ Nervousness	□ Shortness of Breath	□ Fatigue	□ Depression
□ Tension	□ Irritability	□ Chest Pains	□ Dizziness
□ Lights Bother Eyes	□ Buzzing in Ears	□ Face Flushed	□ Cold Sweats
□ Fever	□ Loss of Memory	□ Ears Ringing	□ Loss of Balance

Have you been under drug and medical care? _____
What medications are you taking? _____
How long? _____ Have you had surgery? ☐ Yes ☐ No What? _____ When? _____
What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's Side	□	□	□	□	□
Mother's Side	□	□	□	□	□

About Your Care:

*Chiropractic Provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.*

General Function Index Questionnaire

Patient Name : _____ #:_____

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by your heath condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your heath condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed. **PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES**. A score of "0" means no disability at all, and a score of "10" means that all the activities in which you would normally be involved have been totally disrupted or prevented by your heath condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — **Totally unable to function**

1. **Family/Home Responsibilities**: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.)

_____

2. **Recreation**: hobbies, sports, and other similar leisure time activities.

_____

3. **Social Activities**: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.

_____

4. **Occupation**: activities that are part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or a volunteer worker.

_____

5. **Self Care**: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)

_____

6. **Life Support Activities**: basic life supporting behaviors such as eating, sleeping, and breathing.

_____

Patient Signature:_____ **Date:**_____

Forbes Chiropractic

Patient Name:_____Date: _____

Pain Scale

Please circle the number that best describes your pain:

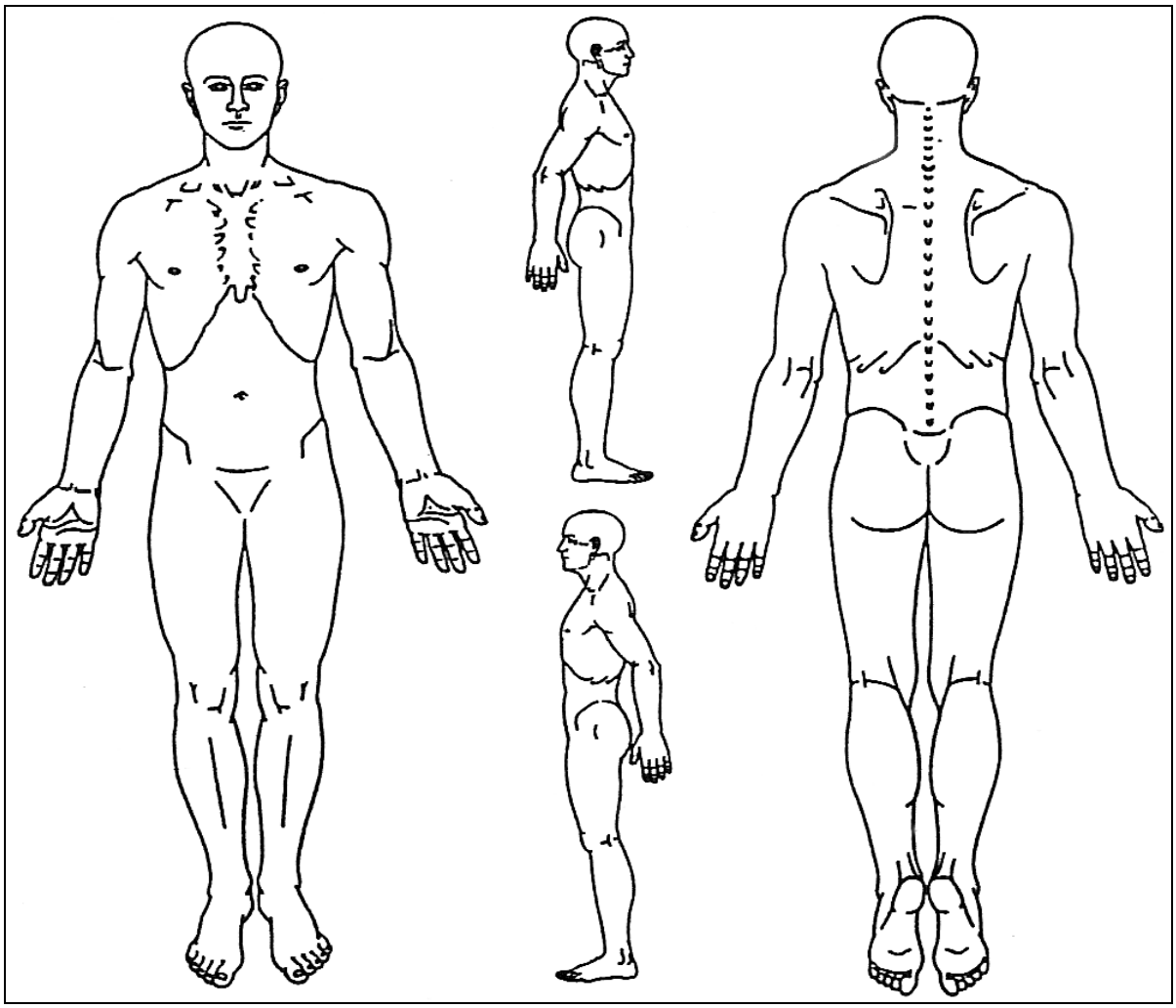
0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Place an "X" on the drawing below on all areas that are causing you pain.
You should also describe, with the associated letter, the type of pain.
(A=Ache, B= Burning, S=Stabbing, N=Numbness, P= Pins and Needles)

How long have you had this pain? __ Yrs ___Months ___Weeks ___Days___Hrs

Is this the first episode of this pain? ☐Yes ☐No



*DR NOTES:*_____

_____

Forbes Chiropractic

NOTICE OF PRIVACY PRACTICES

This notice describes how and why your health information may be used and how you can gain access to this information. Please review the information carefully.

(If there are any areas which you might need more clarification on please do not hesitate to ask.)

Why A Privacy Policy Now?

The most significant variable which motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of electronic technology in the health care business. The government has sought to standardize and protect the electronic exchange of your health information. This has challenged us to review how your information is used within our computers, on the Internet, as well as phones, fax machines, and any device used to copy or transfer patient data. We want to advise you that we have developed policies and procedures for our practice to insure your personal health information will be shared only as required for the purpose of administering your care. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We also want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business. Be assured that without your written permission, your health information will not be used for any other purpose.

Why Your Health Information May Be Used To Provide Treatment:

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and office personnel. In addition, we may share this information with referring physicians, clinical radiological laboratories, or other health professionals providing treatment. Here are some of the reasons we may need to share information.

In Patient Reminders

Because we believe your health goals are very important to your overall care and treatment plan, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy, which is to partner with our patients to see they receive the best chiropractic care we can provide. This may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail. **(Please tell us if you prefer not to receive these types of reminders or notifications**).

To Obtain Payment

Your health information may be included with an invoice in order to collect payment for the services provided to you in this office. We may do this with insurance forms filed for you electronically or by mail. We will make every effort to work with companies with a similar commitment to the security of your health information.

Public Health and National Security

We may be required to disclose necessary health information to Federal officials or military authorities in order to complete investigations related to public health and or national security.

For Law Enforcement

As permitted or required by State and Federal law, we may disclose your health information under certain circumstances to proper authorities for the purpose of law enforcement. This may take place if you are a victim of a crime, or in order to report a suspected crime.

Family and/or Care Givers

We may share your health information with those that assist you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable to communicate your wishes, we will use our very best judgment when sharing your health information with anyone participating in your care.

Authorization to Use or Disclose Health Information

Other than the information stated above, or information that Federal, State, and Local laws require, we will not disclose your health information without your written authorization.

Patient Rights
This law is careful to describe that you have rights related to your health information. Be assured that we will make every effort to honor reasonable restriction preferences, and that you may revoke any authorization in writing at any time.

Confidential Communications
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately, with or without other family members present, or through sealed mail communications. We will make all reasonable efforts to honor your request.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information. This includes your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know**. We may need to charge you a reasonable fee to duplicate and assemble your copy.**

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. Please make any request to amend health information, in writing and describe as completely as possible, the reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested, sealed, and/or delivered to any authority for review.

Documentation of Health Information
You have the right to request a description of how our office used your health information for reasons other than treatment, payment, or health care operations. Our documentation procedure will enable us to provide information on your health information usage from the first day of your treatment in our office forward. Please let us know, in writing, the time period for which you are interested.

Request a Paper Copy of This Notice
You have the right to request and obtain a copy of this “Notice of Privacy Practices” at any time. We are required by law to maintain privacy of health information and provide a copy of this “Notice of Privacy Practices” upon request. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. You will be notified of any such changes. You have the right to express concerns or complaints to Forbes Chiropractic or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Our Promises
We want to assure you that we take the Federal HIPPA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We promise you that your personal health information will be protected by these laws and not to be unnecessarily disclosed to others outside our office.

Patient Acknowledgment
Thank you for taking time to review how your health information is protected and used in our office. If you have questions, please let us know. Please acknowledge that you have received, thoroughly reviewed, and understand this policy by signing on the line below. Thank you.

Patient Name (please print)

Signature **Date**
(Patient or guardian)

Forbes Chiropractic
Informed Consent for Chiropractic Care

When a patient seeks Chiropractic care and we accept a patient for such care, it is essential for both parties to be working towards the same objectives. It is important that every patient understand both the objectives and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care to be provided so that you may make the decision whether or not to undergo Chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of Chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

VIC_____
Doctor's Initials

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____	_____	_____
Parent Print Name	Signature	Date

Vaccine Policy

I HAVE had one or more COVID vaccines

Yes / No

☐ ☐

I agree to give myself at least FOUR WEEKS after choosing to receive ANY VACCINE or BOOSTER before my next appointment with any physician at Forbes Chiropractic.

Yes / No

☐ ☐

Office Appointment Policy

Every patient in our practice receives a personal reservation, dedicated just to you. Please reschedule your appointment at least 24 hours before your reserved appointment. This courtesy makes it possible to give your reserved time slot to another patient on the waiting list, who would be more than happy to accept. You will receive a courtesy text or e-mail as a reminder. I understand that repeated cancellations or missed appointments will result in loss of future appointment privileges, as well as be removed from the schedule for any remaining appointments for the year. ***Any cancellation or reschedule made less than 24hrs before reserved appointment will result in a cancellation fee.***

Yes / No

☐ ☐

We DO NOT bill or accept insurance.

Our office does not accept insurance, nor bill or give out superbills/receipts for insurance reimbursement. We have discovered that it is less expensive for patients to receive regular chiropractic and nutritional care, than it would be to raise our fees and hire an entire staff to deal with insurance requests and denials, so that patients receive minimal reimbursement. Our main focus is caring for patients, rather than charging extra to cover the cost of dealing with insurance paperwork. If you would like a referral to a Doctor of Chiropractic who bills insurance, we will be glad to give you one.

I UNDERSTAND THAT DR. SCOTT FORBES DOES NOT ACCEPT INSURANCE AND WILL NOT SUBMIT OR GIVE FORMS FOR INSURANCE SUBMISSION/REIMBURSEMENT.

Yes / No

☐ ☐

I want to receive appointment reminders AND periodic office information newsletters via e-mail.

Yes / No

☐ ☐

By submitting this questionnaire for a consultation/appointment, I agree to release Scott Forbes, DC / Forbes Chiropractic /all liability.

_____ _____

Signature Date