Welcome to Healing Touch Family Chiropractic

Please print clearly and fill in completely.

Print Name________________________________ **Email**____________________

Phone________________ **SS#**________________ **Address**____________________

City________________ **State**______ **Zip**__________ **Date of Birth**____________

Please Check ✓ **Sex: Male** ☐ **Female** ☐ **Right handed** ☐ **Left handed** ☐ **Married** ☐ **Single** ☐

Health History:

Give reason for seeking chiropractic care:________________________________

Describe any health problems, including how long you've had them:____________________

Are you under the care of any other doctor? Yes ☐ No ☐

If yes, the conditions being treated for:________________________________

List any current medications/supplements:________________________________

List any past surgeries & dates:________________________________

List any past accidents & dates:________________________________

List any x-rays you've had in the past 2 years:________________________________

Personal & Family History:

Your Occupation:____________________ Work Duties:____________________

Spouse's name and health status________________________________

Children's ages and health status:________________________________

Chiropractic History:

Have you ever been to a chiropractor before? Yes ☐ No ☐ If yes, doctor's name:________________

Date of last chiropractic visit:________________ Reason for care:________________

Date of last chiropractic x-rays:________________ How long were you under care?________________

Are other family members under chiropractic care? Yes ☐ No ☐ If yes, who?________________

Wellness Commitment:

At this chiropractic office, we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How did you hear about our clinic?________________________________

FEMALES: ***Please Check*** ✓ Is there a possibility of you being pregnant? Yes ☐ No ☐

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with ____________ and assign directly to Healing Touch Family Chiropractic, P.C. 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 the insurance. I authorize the use of my signature on all insurance submissions. Doctor Blair Copp may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

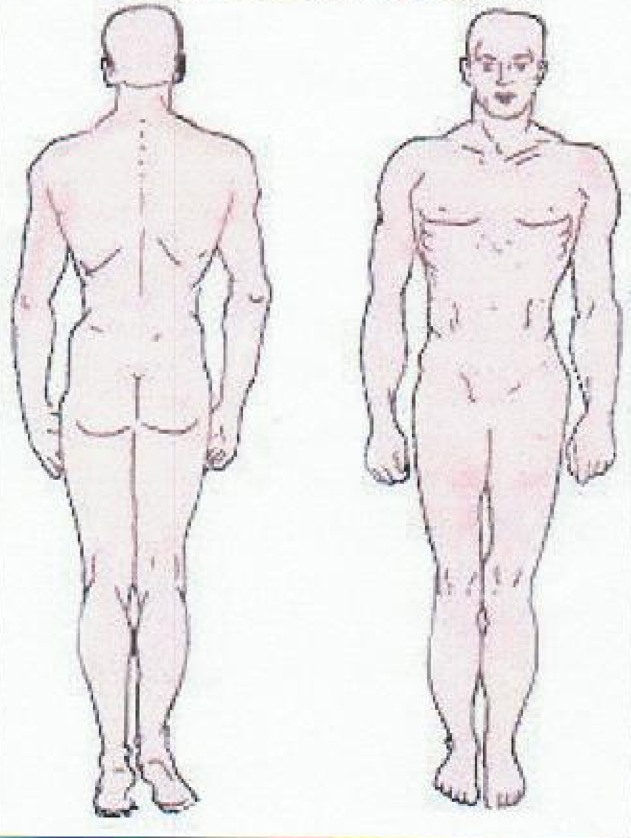
Printed Name of Patient/Parent:____________________ Signature:____________________

Date:________________

Please Fill in Below If you have had the following, or if you suffer from the following, ***Please Check*** ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other ________	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

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Thank you for being complete and thorough.

Your Signature Below Please

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Date: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the County Health Department's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the notice, and I request the following restrictions concerning the use of my personal medical information.

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Signed:______________________________ Date:________________________

*If not signed by the patient, please indicate your relationship to the patient (e.g., spouse, parent, etc.)

Relationship:______________________________________

Witnessed by:______________________________________

Internal Use Only: If a patient or patient's representative refused to sign the following Acknowledgement Receipt of Notice, please document the date and time the notice was presented to the patient and sign below.

Presented on:________________ By:________________________ Title:____________________