The Center for Family Wellness

New Patient Health Record

Welcome to our office. Please complete all of the following questions.

Patient Information

Patients Last Name: **First:** **Middle Initial:** **Nickname:** **Birth Date:**

Address: **City:** **State:** **Zip:**

Home Phone: **Work Phone:** **Cell Phone:** **E-Mail:**

Social Security Number: - - **Sex:** ☐ Male ☐ Female **Marital Status:**

How did you hear about our office? **Emergency Contact:**

Communication & Electronic Health Records:

Preferred Type of Communication? ☐Cell Phone ☐ Home Phone☐ Work Phone ☐Email ☐ In Person

Preferred Appointment Reminder? ☐ Email ☐ Text Message ☐ Phone Call

Preferred Language? ☐ English ☐ Spanish ☐ German ☐ French ☐ Italian ☐ Russian ☐ Portuguese ☐ Chinese ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Decline to Answer ☐ Other _______________

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic nor Latino ☐ Declined to Answer

Smoking Status: ☐ Never ☐ Current Everyday ☐ Occasional ☐ Former Start Year: _________ Quit date: ________

Insurance Information

Insurance Carrier: **Member ID:** **Group Number:**

Policy Holders Name: **Date of Birth:**

Relationship: ☐ Self ☐ Spouse ☐ Parent **Policy Holders Employer:**

Is There a Secondary Policy? ☐ Yes ☐ No **Insurance Carrier:** **Member ID:**

Patient Information

Current Medications: Please list all medication you are currently taking including Prescription, Over the Counter, Supplements and Vitamins. ***If you need more space please use the back of this paper.***

Drug Name: _______________Strength_________Dose___________Frequency__________Started________

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Drug Name: _______________Strength_________Dose___________Frequency__________Started________

Drug Allergies:

Drug Name: _______________Reaction ___________Started_________

Drug Name: _______________Reaction ___________Started_________ **Date of Last Physical**: __________

Drug Name: _______________Reaction ___________Started_________

Have You Been Treated by a Physician in the last 12 Months? ☐ Yes ☐ No **Name of Doctor?** ___________

Please Describe the Condition? ____

Are you currently pregnant? ☐Yes ☐No **Do you have any Implants?** ☐ Yes ☐ No

Social History

Alcohol Use: ☐None ☐Light ☐Moderate ☐Heavy

Drug Use: ☐None ☐Light ☐Moderate ☐Heavy

Tobacco Use: ☐None ☐Light ☐Moderate ☐Heavy

Exercise: ☐None ☐Light ☐Moderate ☐Heavy

Water Intake:☐None ☐Light ☐Moderate ☐Heavy

Average Sleep per Night? ________________Hours

Type of Pillow You Use? _____________________

Eating Habits? ☐Skip Breakfast ☐Two Meals a Day ☐ Three Meals a Day ☐ Snacking

Operations & Injuries

Please list any surgical procedures you have had. ***If you need more space please use the back of this paper.***

Surgery _______________________________ Date ___________________

Surgery _______________________________ Date ___________________

Surgery _______________________________ Date ___________________

Please list any accidents you have had in the past.

Accident _____________________________Date ___________ Due To: ☐Work ☐Auto Accident ☐Other

Accident _____________________________Date ___________ Due To: ☐Work ☐Auto Accident ☐Other

Accident _____________________________Date ___________ Due To: ☐Work ☐Auto Accident ☐Other

Patient History

Please mark any conditions you currently have or have had in the past.

☐ AIDS	☐ Allergies	☐ Anemia	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Bladder Trouble	☐ Bone Fracture	☐ Cancer	☐ Chest Pain
☐ Concussion	☐ Constipation	☐ Convulsions	☐ Depression	☐ Diarrhea
☐ Dislocated Joints	☐ Epilepsy	☐ Fibromyalgia	☐ German measles	☐ Headache
☐ Heart trouble	☐ Hepatitis	☐ Herniated Disk	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/ARC	☐ Kidney Disorder	☐ Loss of Bowel Control	☐Lung Disease	☐Menstrual Cramps
☐Migraines	☐Multiple Sclerosis	☐Muscular Dystrophy	☐Neck Pain	☐Nervousness
☐Numbness	☐Osteoporosis	☐Parkinson's Disease	☐Pinched Nerve	☐Polio
☐Poor Circulation	☐Reproductive Disorder	☐Rheumatic Fever	☐Rheumatism	☐Rheumatoid Arthritis
☐Scarlet Fever	☐Scoliosis	☐Serious Injury	☐Sinus trouble	☐Stroke
☐Thyroid Problems	☐Tuberculosis	☐Tumors or growths	☐Ulcers	☐Venereal Disease

Family History

Please mark any conditions that you or an immediate family member has been diagnosed with.
Mark with a **S** for **Self**, **M** for **Mother**, **F** for **Father**, **I** for **Sister**, **B** for **Brother**, **D** for **Daughter** or **O** for **Son**.

_________ Bone Cancer
_________ Brain Cancer
_________ Breast Cancer
_________ Colon Cancer
_________ Esophageal Cancer
_________ Gastric Cancer
_________ Kidney Cancer
_________ Leukemia
_________ Liver Cancer
_________ Muscle Cancer
_________ Ovarian Cancer
_________ Pancreatic Cancer
_________ Prostate Cancer
_________ Rectal Cancer
_________ Skin Cancer
_________ Thyroid Cancer
_________ Clotting Disorder
_________ Deep Vein Thrombosis
_________ Pulmonary Embolism
_________ Clotting Disorder
_________ Dementia/Alzheimer
_________ Diabetes
_________ Gestational Diabetes
_________ Impaired Fasting Glucose
_________ Insulin Resistance
_________ Maturity Onset Diabetes
_________ Pre-Diabetes
_________ Type 1 Diabetes
_________ Type 2 Diabetes
_________ Colon Polyp
_________ Crohn's Disease
_________ Gastrointestinal Disorder
_________ Irritable Bowel
_________ Ulcerative Colitis
_________ Lynch Syndrome
_________ Angina
_________ Coronary Artery Disease

_________ Heart Attack
_________ Heart Disease
_________ Hypertension
_________ Cystic Kidney Disease
_________ Chronic Kidney Disease
_________ Congenital Kidney Disease
_________ Kidney Nephrosis
_________ Nephritis
_________ Nephrotic Syndrome
_________ Asthma
_________ COPD
_________ Chronic Bronchitis
_________ Lower Respiratory Disease
_________ Emphysema
_________ Influenza
_________ Pneumonia
_________ Osteoporosis
_________ Anxiety
_________ ADHD
_________ Autism
_________ Bipolar Disorder
_________ Dementia
_________ Depression
_________ Eating Disorder
_________ Mental Disorder
_________ OCD
_________ Panic Disorder
_________ Personality Disorder
_________ PTSD
_________ Schizophrenia
_________ Social Phobia
_________ Septicemia
_________ Stroke/Brain Attack
_________ Sudden Infant Death

Symptoms

Please mark below your **Primary** symptom (***Only Select One, use separate page for each symptom***)

______ Headache
______ Neck Pain
______ Upper Back Pain
______ Mid Back Pain
______ Low Back Pain
______ Left Shoulder Pain
______ Right Shoulder Pain
______ Left Hip Pain
______ Right Hip Pain
______ Left Knee Pain
______ Right Knee Pain

Please rate your pain on a scale of 1-10, with 10 being the worst imaginable. ______

Please describe your pain:

- ☐ Aching
- ☐ Burning
- ☐ Cramping
- ☐ Deep
- ☐ Diffuse
- ☐ Dull
- ☐ Numbness
- ☐ Radiating
- ☐ Sharp
- ☐ Shooting
- ☐ Stiff
- ☐ Tight
- ☐ Tingling

How often:

- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

Pain Cause

- ☐ A Fall
- ☐ Work Injury
- ☐ Auto Accident
- ☐ Illness
- ☐ Lifting Injury
- ☐ Unknown
- ☐ Gradual Onset

Pain radiates into:

- ☐ Left Arm
- ☐ Left foot
- ☐ Left Hand
- ☐ Left Leg
- ☐ Left Shoulder
- ☐ Right Arm
- ☐ Right Foot
- ☐ Right Hand
- ☐ Right Leg
- ☐ Right Shoulder

Pain Pattern:

- ☐ Better in Morning
- ☐ Better in Afternoon
- ☐ Better in evening
- ☐ Worse in Morning
- ☐ Worse in Afternoon
- ☐ Worse in Evening
- ☐ Consistent
- ☐ Unchanged

Prior Interventions:

- ☐ Acupuncture
- ☐ Prescription Medicine
- ☐ Massage
- ☐ Surgery
- ☐ OTC Medicines
- ☐ Chiropractic

Pain Duration:

- ☐ _______ Day(s)
- ☐ _______Weeks(s)
- ☐ _______Months(s)
- ☐ _______Year(s)

Aggravated by:

- ☐ Bending
- ☐ Driving
- ☐ Getting up/down
- ☐ Increased Activity
- ☐ Looking Down
- ☐ Overhead Activities
- ☐ Reaching
- ☐ Sitting
- ☐ Standing
- ☐ Typing
- ☐ Coughing
- ☐ Exercising
- ☐ House Work
- ☐ Lifting
- ☐ Lying Down
- ☐ Preparing Food
- ☐ Resting
- ☐ Sneezing
- ☐ Twisting
- ☐ Walking

Relived by:

- ☐ Exercise
- ☐ Ibuprofen
- ☐ Knees Bent Up
- ☐ Lying Down
- ☐ No Movement
- ☐ Resting
- ☐ Standing
- ☐ Support
- ☐ Walking
- ☐ Heat
- ☐ Ice
- ☐ Lifting
- ☐ Medication
- ☐ Reaching
- ☐ Sitting
- ☐ Stretching
- ☐ Turning Head

Select Daily Activities that are impaired because of this symptom:

- ☐Computer Use (extended)
- ☐Computer Use(Short Time)
- ☐Concentrating
- ☐Cycling
- ☐Desk Work
- ☐Drawing
- ☐Exercise
- ☐Lying Down
- ☐Reading
- ☐Running
- ☐Sitting
- ☐Standing
- ☐Using The Phone
- ☐Walking
- ☐Yard Work
- ☐Bathing
- ☐Bending
- ☐Child Care
- ☐Falling Asleep
- ☐Dressing
- ☐Golf
- ☐Kneeling
- ☐Lifting
- ☐Looking Over Shoulder
- ☐Driving
- ☐Staying Asleep
- ☐Climbing Stairs
- ☐Lying Down
- ☐Sitting
- ☐Other __________

Symptoms

Please mark below your **Secondary** symptom (***Only Select One, use separate page for each symptom***)

______ Headache	______ Low Back Pain	______ Right Hip Pain
______ Neck Pain	______ Left Shoulder Pain	______ Left Knee Pain
______ Upper Back Pain	______ Right Shoulder Pain	______ Right Knee Pain
______ Mid Back Pain	______ Left Hip Pain	

Please rate your pain on a scale of 1-10, with 10 being the worst imaginable. ______

Please describe your pain:

- □ Aching
- □ Burning
- □ Cramping
- □ Deep
- □ Diffuse
- □ Dull
- □ Numbness
- □ Radiating
- □ Sharp
- □ Shooting
- □ Stiff
- □ Tight
- □ Tingling

How often:

- □ Constant
- □ Frequent
- □ Intermittent
- □ Occasional

Pain Cause

- □ A Fall
- □ Work Injury
- □ Auto Accident
- □ Illness
- □ Lifting Injury
- □ Unknown
- □ Gradual Onset

Pain radiates into:

- □ Left Arm
- □ Left foot
- □ Left Hand
- □ Left Leg
- □ Left Shoulder
- □ Right Arm
- □ Right Foot
- □ Right Hand
- □ Right Leg
- □ Right Shoulder

Pain Pattern:

- □ Better in Morning
- □ Better in Afternoon
- □ Better in evening
- □ Worse in Morning
- □ Worse in Afternoon
- □ Worse in Evening
- □ Consistent
- □ Unchanged

Prior Interventions:

- □ Acupuncture
- □ Prescription Medicine
- □ Massage
- □ Surgery
- □ OTC Medicines
- □ Chiropractic

Pain Duration:

- □ _______ Day(s)
- □ _______Weeks(s)
- □ _______Months(s)
- □ _______Year(s)

Aggravated by:

□ Bending	□ Overhead Activities	□ Coughing	□ Preparing Food
□ Driving	□ Reaching	□ Exercising	□ Resting
□ Getting up/down	□ Sitting	□ House Work	□ Sneezing
□ Increased Activity	□ Standing	□ Lifting	□ Twisting
□ Looking Down	□ Typing	□ Lying Down	□ Walking

Relived by:

□ Exercise	□ Resting	□ Ice	□ Stretching
□ Ibuprofen	□ Standing	□ Lifting	□ Turning Head
□ Knees Bent Up	□ Support	□ Medication	
□ Lying Down	□ Walking	□ Reaching	
□ No Movement	□ Heat	□ Sitting	

Select Daily Activities that are impaired because of this symptom:

□Computer Use (extended)	□Exercise	□Using The Phone	□Falling Asleep	□Driving
□Computer Use(Short Time)	□Lying Down	□Walking	□Dressing	□Staying Asleep
□Concentrating	□Reading	□Yard Work	□Golf	□Climbing Stairs
□Cycling	□Running	□Bathing	□Kneeling	□Lying Down
□Desk Work	□Sitting	□Bending	□Lifting	□Sitting
□Drawing	□Standing	□Child Care	□Looking Over Shoulder	□Other __________

Symptoms

Please mark below your any other symptom (***Only Select One, use separate page for each symptom***)

______ Headache	______ Low Back Pain	______ Right Hip Pain
______ Neck Pain	______ Left Shoulder Pain	______ Left Knee Pain
______ Upper Back Pain	______ Right Shoulder Pain	______ Right Knee Pain
______ Mid Back Pain	______ Left Hip Pain	

Please rate your pain on a scale of 1-10, with 10 being the worst imaginable. ______

Please describe your pain:

- □ Aching
- □ Burning
- □ Cramping
- □ Deep
- □ Diffuse
- □ Dull
- □ Numbness
- □ Radiating
- □ Sharp
- □ Shooting
- □ Stiff
- □ Tight
- □ Tingling

How often:

- □ Constant
- □ Frequent
- □ Intermittent
- □ Occasional

Pain Cause

- □ A Fall
- □ Work Injury
- □ Auto Accident
- □ Illness
- □ Lifting Injury
- □ Unknown
- □ Gradual Onset

Pain radiates into:

- □ Left Arm
- □ Left foot
- □ Left Hand
- □ Left Leg
- □ Left Shoulder
- □ Right Arm
- □ Right Foot
- □ Right Hand
- □ Right Leg
- □ Right Shoulder

Pain Pattern:

- □ Better in Morning
- □ Better in Afternoon
- □ Better in evening
- □ Worse in Morning
- □ Worse in Afternoon
- □ Worse in Evening
- □ Consistent
- □ Unchanged

Prior Interventions:

- □ Acupuncture
- □ Prescription Medicine
- □ Massage
- □ Surgery
- □ OTC Medicines
- □ Chiropractic

Pain Duration:

- □ _______ Day(s)
- □ _______Weeks(s)
- □ _______Months(s)
- □ _______Year(s)

Aggravated by:

□ Bending	□ Overhead Activities	□ Coughing	□ Preparing Food
□ Driving	□ Reaching	□ Exercising	□ Resting
□ Getting up/down	□ Sitting	□ House Work	□ Sneezing
□ Increased Activity	□ Standing	□ Lifting	□ Twisting
□ Looking Down	□ Typing	□ Lying Down	□ Walking

Relived by:

□ Exercise	□ Resting	□ Ice	□ Stretching
□ Ibuprofen	□ Standing	□ Lifting	□ Turning Head
□ Knees Bent Up	□ Support	□ Medication	
□ Lying Down	□ Walking	□ Reaching	
□ No Movement	□ Heat	□ Sitting	

Select Daily Activities that are impaired because of this symptom:

□Computer Use (extended)	□Exercise	□Using The Phone	□Falling Asleep	□Driving
□Computer Use(Short Time)	□Lying Down	□Walking	□Dressing	□Staying Asleep
□Concentrating	□Reading	□Yard Work	□Golf	□Climbing Stairs
□Cycling	□Running	□Bathing	□Kneeling	□Lying Down
□Desk Work	□Sitting	□Bending	□Lifting	□Sitting
□Drawing	□Standing	□Child Care	□Looking Over Shoulder	□Other __________

The Center for Family Wellness

Office Policies.

HIPPA Notice

I understand and agree to allow this Chiropractic Office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of our policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA Notice that is available for you at the Front Desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Patient's Signature: (parent if minor) ______________________________Date: ____________

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic evaluations to include chiropractic examinations, chiropractic care and if necessary, diagnostic x-rays on me by the doctor of The Center for Family Wellness and/or anyone authorized by the same doctor. I further understand the doctor will do his best to explain testing and treatment before administering it, and am informed that, as in all health care, there are some slight risks to treatment. I do not expect the doctor to be able to anticipate or explain all risks and combinations. I will rely on the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time, is in my best interest. I have read this consent and intend this consent form to cover the entire course of my care for this condition and any care in the future.

Patient's Signature: (parent if minor) ______________________________Date: ____________

Financial Policy

Thank you for choosing us as your health care provider. The following is a description of our financial policy:

- Payment for services is due at the time services are rendered.
  - We accept cash, check and all major credit cards.
  - We reserve the right to collect before services are rendered.
- All charges are your responsibility whether the insurance company pays or not.
  - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
  - Fees for non-covered services, deductibles and co-payments are due at the time of treatment.
  - If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service and or supply is denied, we may require you to follow up with your insurance and/or pay the balance due.
- Unless you insured by Medicare or an insurance group which our doctors are participating members, or double insured (for treatment being performed), it is our policy to collect 100% payment at the time the services are rendered.
- If you are a member of an HMO or Managed Care Program or have a PCP(Primary Care Physician), you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your agreement with your insurance company.
- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with our Office Manager if you encounter such problems, so that we may assist you in the management of your account.

Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient's Signature________________________________ Date________________