Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Drinking Status (Circle One): Never/ Rarely / Social Drinks Beer or Liquor:_____/day, week, month

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Prior Health History, Mark all the apply

❍ Fatigue
❍ Fever
❍ Weight Gain/Loss

❍ Blurred Vision
❍ Change in Vision
❍ Glaucoma
❍ Macular Degeneration
❍ Wears Glasses or Contacts

❍ Difficulty Swallowing
❍ Hearing Loss
❍ Loss of Smell
❍ Sinus Infections
❍ Snoring
❍ Ringing in Ears

❍ Asthma
❍ Emphysema
❍ Oxygen needed
❍ Shortness of Breath

❍ Strokes

❍ Heart Problems
❍ High Blood Pressure
❍ High Cholesterol
❍ Irregular heartbeat
❍ Shortness of Breath
❍ Varicose Veins

❍ Abdominal Pain
❍ Constipation
❍ Heartburn
❍ Hemorrhoids
❍ Indigestion
❍ Nausea
❍ Abnormal Stool Consistency
❍ Ulcer

Female:
❍ Birth Control Therapy
❍ Hormone Therapy
❍ Irregular Menstruation
❍ Abnormal Bleeding
❍ Currently Pregnant
❍ Pregnant in the past

Male:
❍ Erectile Dysfunction
❍ Hesitancy/Dribbling
❍ Prostate Problems

❍ Diabetes

❍ Excessive Thirst
❍ Frequent Urination
❍ Goiter
❍ Hair Loss

❍ Bruises easily
❍ Itching

❍ Numbness, tingling
❍ Rash
❍ Sores won't heal

❍ Dizziness
❍ Headaches
❍ Limb Weakness
❍ Loss of Memory
❍ Numbness
❍ Seizures
❍ Stress
❍ Strokes
❍ Tremors

❍ Anxiety
❍ Confusion
❍ Dementia
❍ Depression
❍ Memory Loss
❍ Mood Changes

❍ Allergies (Please list)

____
____
____

❍ Anemia
❍ Blood Clotting
❍ Bruises easily

❍ Fatigue
❍ Lymph Node Swelling

Childhood Illnesses:
❍ ADD/ADHD
❍ Asthma

❍ Bedwetting
❍ Diabetes
❍ Ear Infections
❍ Chicken Pox
❍ Measles
❍ Mumps
❍ Food Allergies
❍ Headaches
❍ Scoliosis

Other childhood diseases:

____
____
____

Adult Illness:
❍ Arthritis
❍ Cancer
❍ Crohn’s/Colitis
❍ Cystic Kidney disease
❍ Depression
❍ Emphysema
❍ Fibromyalgia
❍ Hypertension
❍ Liver Disease
❍ Parkinson's Disease
❍ Seizure Disorder
❍ Shingles
❍ Thyroid Problems

❍ Vertigo

Other Adult diseases:

____
____
____

Surgeries (Please list ...)

____
____
____

Family history (ex: dad- illness)

____
____
____

Past injury

____
____
____

Welcome to our office! This paperwork provides the vital information required to be a patient! Our staff will personally interview you for the condition or concerns that bring you here!

Full Legal Name: _______________________________ Preferred Name:______________________________
Address: ___________________________________ City / State / Zip:__________________________________
Home Phone: (   )_________________________ Mobile Phone: (   )________________________________
Birth Date: ________________________________ Age: _______________________________ Sex ❍ M ❍ F
Social Security #: ____
E-mail: ____
Marital Status: ❍ S ❍ M ❍ D ❍ W Spouse's Name __________________________ # of Children _________

Occupation:____
Employer's Name:______________________________________ Work Phone: (   ) ____________________

How were you referred to Ambient Chiropractic P.A.? ____

Insurance:
Insurance Type: ____
Policyholder: ____ DOB: ________________________

Emergency Contact:
Name: ____ Relation:______________________
Home Phone: ___________________________Work Phone: ____________________________________

Information may be release to the following individuals (such as spouse, mother, father):
* No information will be released to anyone unless noted here, including billing or statement information.
Name: _______________________________________ Date of Birth: _________________________________
Name: _______________________________________ Date of Birth: _________________________________
Name: _______________________________________ Date of Birth: _________________________________

Areas of Interest:
○ Nutritional Supplements
○ Detoxification
○ Headaches
○ Weight Loss Information
○ Women's Health
○ Neck/Body Pillows
○ Decompression
○ Acupuncture
○ Wellness Care
○ Children's Care
○ Ear Infection/Colic/ADD
○ Massage
○ Others (Please list):
____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _______________________________________ , have been informed, understand and agree to the Notice of Privacy Practices of Ambient Chiropractic P.A. which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. I have be offered the full policy pamphlet.

Signature: _______________________________ **Print Name:** ________________________________

Clinical Summary

I choose to decline receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature and frequency of chiropractic care).

Signature: ____

Authorization and Assignment

I authorize Ambient Chiropractic P.A. to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Ambient Chiropractic P.A. authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

I understand if I do not provide Ambient Chiropractic P.A. with insurance information within my insurance companies timely filing guidelines, Ambient Chiropractic P.A. has the right to not submit to my insurance company and the balance is my responsibility to pay in full.

Signature: ____ **Date:** ___________________

Informed Consent

I hereby authorize physicians and staff at Ambient Chiropractic P.A. to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Ambient Chiropractic P.A. responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, ten- don, or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Signature: ____ **Date:** ___________________

Consent to Treat a Minor

I, as a parent/legal guardian of ______________________________ authorize appropriate chiropractic care.

Signature: ____ **Date:** ___________________