

Patient Information

Patient Name _____
 Address _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Email: _____
 Sex: M F Age: _____ Birthday: _____
 Married Widowed Single Minor
 Separated Divorced Partnered
 Have you been to a chiropractor before? _____
 When was your last visit? _____

Employer/School _____
 Occupation _____
 Spouse's Name _____
 Spouse's Employer _____
 Spouse's Occupation _____
IN CASE OF EMERGENCY, PLEASE CONTACT:
 Name _____
 Relationship _____
 Contact Number _____
Who may we thank for referring you? _____

How Can We Help You?

Wellness Checkup Other _____

If you are already experiencing a symptom, how long have you been living with it? _____

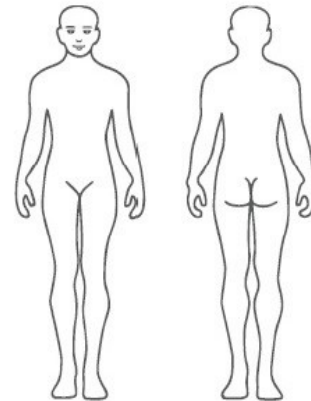
How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10
 NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms.

What does it feel like? (Check where appropriate).

- Numbness Sharp
- Tingling Shooting
- Stiffness Burning
- Dull Throbbing
- Aching Cramping
- Swelling Stabbing
- Nagging Other: _____



Impact of Your Symptoms

How is this symptom/condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10
 NOT COMMITTED VERY COMMITTED

Patient Wellness Assessment

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

- A. What number do you think represents your health today? _____
- B. In what direction is your health currently headed? _____

What are your health goals?

Immediate: _____

Short Term: _____

Long Term: _____

Children & Pregnancy

How many children do you have? _____ Are you currently pregnant? No Yes, I am Due: _____

Children's ages? _____ Number of past pregnancies: _____

Children's health concerns? _____ Health concerns regarding this pregnancy: _____

Health & Illness History

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Circulation Issues | <input type="checkbox"/> Headache/Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Childhood Illness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hip Issues | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Immune Issues | <input type="checkbox"/> TMJ Issues |
| <input type="checkbox"/> Asthma/Allergies | (Constipation, Diarrhea, GERD, IBS) | <input type="checkbox"/> Lymphatic Issues | <input type="checkbox"/> Urinary Issues |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Elbow/Wrist/Hand Issues | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Endocrine Issues (Thyroid) | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Foot/Ankle Issues | <input type="checkbox"/> Reproductive Issues | _____ |

Allergies, Medications, & Supplements

Allergies: _____ Medications: _____ Supplements: _____

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

- PATIENT
 SPOUSE
 PARENT
 WORKERS COMP
 AUTO INSURANCE
 MEDICARE
 HEALTH INSURANCE

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

Photo and Video Permission

I give Family First Chiropractic Wellness Center permission to take pictures and videos of me _____
I am aware that the photos taken may be used in office promotion, fliers, social networks, such as facebook or twitter and/or website www.ffcwc.com. Videos will be used for training purposes only.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

What FFCWC is all about...

Our Vision: It is our vision that every man, woman, and child be checked regularly for subluxation throughout their lives.

Our Mission: It is our mission to educate and adjust as many families as possible toward optimal expression of life, utilizing the principles and paradigm of chiropractic to empower you to take control of your health.

Our Purpose: To provide the best opportunity for members of our community to live long, healthy, happy lives from their first breath to the last so they can fully engage in life and provide value to their families and community.

Our Premise: Families that are in our office are more equipped to handle the stress of everyday life.

Our Core Values:

Passion: We have a passion for service, life, and chiropractic.

Professionalism: We exhibit the skill, judgement, and behavior that is expected from a person who is trained to do a job well.

Teamwork: Our team works together by combining each of our unique strengths to create an environment that allows us to provide outstanding value to our community in a very simple and efficient way.

Love: Our service to our community is rooted by an unselfish and compassionate concern for the good of each individual we care for.

Authenticity: Each member of our team behaves in a manner that allows them to stay true to one's own personality, spirit, and character.

Integrity: We adhere to a code of having high moral values when serving and communicating the chiropractic paradigm to the world.

Simplicity: We act efficiently and communicate in a way that is easy to understand. We are experts at simplifying the complex.