FRYEBURG CHIROPRACTIC & WELLNESS CENTER

Name: _____ DOB: _____ Age: ____ Home Phone : _____

Address:_____ City, State Zip:_____

How did you find out about us? _____

Reason for consulting our office at this time: _____

Employer: _____ Employer Phone : _____

Spouse/Significant Other Name: _____

Children's Names & Ages: _____

Emergency Contact Name: _____ Number: _____Employer: _____

Email Address : _____

Cell/Text Number: _____

Text Carrier:

☐ Alltel	☐ Cingular	☐ Verizon
☐ ATT Wireless	☐ Sprint	☐ Virgin Mobile
☐ Boost	☐ T-Mobile	☐ Other
☐ Cellular One	☐ US Cellular	

APPOINTMENT CONFIRMATION

The day before your scheduled appointment we will contact you to verify the time of your appointment.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Please describe your chief area of complaint, including the effect it has had on your life.

_____

_____

Location ☐Left ☐Right ☐Both sides ☐Front ☐Back ☐In the middle ☐On the side

How did your main problem appear ☐Gradually ☐Suddenly ☐Accident/Trauma ☐Uncertain

Is your problem getting ☐Better ☐Worse ☐Staying the Same

What seems to aggravate this problem? _____

Does it interfere with ☐Work ☐Sleep ☐Walking ☐Sitting ☐Hobbies ☐Leisure

If you are experiencing pain, is it: ☐Sharp ☐Dull/Achey ☐Grabbing Pain ☐Shooting ☐Burning

Does this problem cause the pain to travel to any other areas? ☐Yes (where)_____ ☐No

Rate the intensity of your discomfort (0 – none, 10 – worst imaginable) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

% of time your problem is present ☐100% ☐75% ☐50% ☐25% ☐Less than 25%

Describe any secondary complaints.

_____

_____

Other doctors seen for these problem (please list):

Chiropractors: _____

Medical Doctor: _____

Others: _____

Any other medical conditions:_____

HEALTH PROFILE

As a full spectrum Chiropractic Office we focus on your ability to be healthy. Our goals are first to address the Vertebral Subluxation Complex. Secondly, to offer you the opportunity for improved health potential in the future. On a daily basis, we experience physical, chemical and emotional forces that can accumulate and result in a loss of health potential. Most times the effects are asymptomatic (not even felt until they become serious). Answering the following questions will give us a profile of the issues you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Please answer the following questions to the best of your ability:

	Yes	No	Unsure	Comments / Description
Did you have any childhood illness?	☐	☐	☐	_____
Did you have any serious falls as a child?	☐	☐	☐	_____
Did you play youth sports?	☐	☐	☐	_____
Did you use / take any drugs?	☐	☐	☐	_____
Did you have any surgeries?	☐	☐	☐	_____
Have you fallen/ jumped from a height over three feet (i.e. crib, bunk bed, trees)?	☐	☐	☐	_____
Were you involved in any car accidents as a child?	☐	☐	☐	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐	_____
Did you suffer from any other traumas (physical or emotional)?	☐	☐	☐	_____
Were you vaccinated?	☐	☐	☐	_____
As a child, were you under regular Chiropractic care?	☐	☐	☐	_____
Do/did you smoke?	☐	☐	☐	_____
Do/did you drink alcohol?	☐	☐	☐	_____
Do/did you drink coffee/tea?	☐	☐	☐	_____
Do/did you take vitamins/supplements?	☐	☐	☐	_____
Do/did you have a regular exercise routine?	☐	☐	☐	_____
Do you have any allergies to medications?	☐	☐	☐	_____
Do you have any other allergies? (seasonal / pets / food)	☐	☐	☐	_____

On a scale of 1-10 describe your stress level (1 – none, 10 – extreme): Occupational: _____ Personal: _____

On a scale of Poor-Good-Excellent, describe your: Diet:_____ Exercise: _____ Sleep: _____ General Health: _____

Medications you are currently taking: _____

FAMILY HEALTH PROFILE

Please check list a brief family history (diseases/conditions, age deceased if applicable):

Grandfathers: _____

Grandmothers: _____

Father: _____

Mother: _____

Siblings: _____

_____

Who is your doctor for medical services? _____

ACKNOWLEDGMENT

Name of the person responsible for payment _____

Do you have insurance coverage? ☐Yes ☐No If yes, which company? _____

Subscriber:_____ Subscriber DOB_____

(Name of person who carries insurance)

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. All charges are payable at the time of service unless, previous arrangements have been made. We will bill your insurance company; you will be responsible for any non-covered balance.

I hereby authorize Fryeburg Chiropractic and Wellness Center to furnish information to my insurance carriers concerning my diagnosis and treatment.

Signature: _____Date:_____

This is to certify that Fryeburg Chiropractic and Wellness Center has my permission to take X-rays. **INITIALS** _____
Female Patients: This is to certify that to the best of my knowledge I am NOT pregnant. **INITIALS** _____
Date of onset of last menstrual period _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including a comprehensive exam, diagnostic X-rays, physical therapy techniques, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctor of chiropractic at Fryeburg Chiropractic and Wellness Center.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. This is an extremely rare occurrence. We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I understand the risk of chiropractic adjustments and other recommended procedures and have had any questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I acknowledge that I am aware of Fryeburg Chiropractic and Wellness Center's Privacy Notice. It is posted in the facility for me to read or I may request a paper copy of the Privacy Notice upon request to the Fryeburg Chiropractic and Wellness Center's Privacy Officer. Your signature is required to be compliant with HIPAA regulations.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Name	SS#
Signature	Date
Parent/Guardian/Spouse Signature Authorizing Care	Date