Welcome to our office.

Please fill out the following information as completely as possible.

PATIENT INFORMATION

(Please Print Clearly)

Legal First Name: _____ Nickname_____MI:____Last Name: _____

Street Address: _____City: _____State: _____Zip:_____

Home#: _____-_____-_____ Work #: _____-_____-_____ Cell #: _____-_____-_____

E-Mail Address: _____ Cell Phone Carrier _____

(We do not share your address with anyone. We use e-mail and textsto send appointment reminders, to notify you of last minute office closures, and other general FHCC information/newsletters.)

Sex: □ M □ F Date of Birth: _____Age: _____ Soc.Sec.#: _____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Occupation: _____ Employer Name _____

Spouse's Name: _____ Spouse's Employer: _____

Name and age of children: _____

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? □ No □ Yes (immediately notify front desk) Your Initials:_____
If yes: Date of Accident: _____ Time of Accident _____ Claim #: _____

Pregnant: □Yes □No Pacemaker: □Yes □No Family Physician_____
Emergency Contact (Name, Phone # and relationship)_____

How did you hear about us:
□ Internet/Google Search □ Our Website □ Insurance Carrier Website □ Referred by _____
□ Other _____

Previous Chiropractic Care: □ No □ Yes (When & Where) _____

INSURANCE INFORMATION:

Do you have health insurance that you would like us to submit claims to: □ Yes □ No
If yes, please provide us with your card so that we may make a copy of it.
If your name is not on the insurance card, please fill out the information below for the person listed on the card.

Sex: □ M □ F Date of Birth: _____Soc.Sec.#: _____-_____-_____
Street Address: _____City: _____State: _____Zip:_____
Home#: _____-_____-_____

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA): □ No □ Yes. If yes, what is the remaining balance in the account: $_____

Signature of Patient/Guardian: _____Date: _____

FAMILY HEALTHCARE CHIROPRACTIC CENTER, INC..

Your Health Profile

Why This Form Is Important

As a general focus chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Childhood (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

(Y=Yes; N=No; U=Unsure)

Did you have any childhood illnesses? ___

Did you play youth sports? ___

Did you have any surgeries? ___

Any other traumas (physical or emotional)? ___

Did you have any serious falls as a child? ___

Involved in any car accidents as a child? ___

Were you under regular chiropractic care? ___

If yes, please explain: _____

COMMENTS_____

_____

_____

Adulthood (18 to present)

Do/did you smoke? ___

Have you had any surgeries? ___

Have you been in any accidents? ___

Do/did you play adult sports? ___

Do/did you participate in extreme sports? ___

When was your last medical physical? _____/_____/_____

Were there any concerns? ☐ No ☐ Yes (please explain):_____

Covid Vaccine: __Yes __No

If yes, which one and date of shot(s): __Moderna __Pfizer __J&J__ Other _____Date(s)_____

Were there any adverse reactions to the shot(s): _____

COMMENTS_____

_____

On a scale of 0 – 10 describe your stress level (0=none/10=extreme): Occupational _____ Personal _____

On a scale of Poor, Good or Excellent describe your: Diet _____Exercise_____ Sleep____ General Health____

Office Notes:

_____

_____

Addressing The Issues That Brought You To The Office

Briefly describe the chief area of complaint and the effect it's had on your life: _____

_____

_____

If you are experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Comes and Goes ☐ Travels ☐ Constant

The problem is: ☐ Getting Better ☐ Getting Worse ☐ About the same

It is aggravated by:_____

It is alleviated by:_____

It interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure ☐ Other_____

Doctors seen for this problem:

☐ Chiropractor: _____ ☐ Medical Doctor: _____ ☐ Other: _____

Please check (√) any of the following that you are <u>currently experiencing or have a history of:</u>

☐ Headaches	☐ Loss of balance/dizziness	☐ Liver trouble	☐ Sinus troubles
☐ Ringing in ears	☐ Low back pain	☐ Mid-back pain	☐ Numbness
☐ Allergies	☐ Depression	☐ Heart trouble	☐ Constipation
☐ Neck pain	☐ High/Low BP	☐ Kidney trouble	☐ Asthma
☐ Menstrual trouble	☐ Fatigue	☐ Pains in legs/feet	☐ Pins/needles in arms/hands
☐ Stomach trouble	☐ Diabetes	☐ Nervousness	☐ Tight of shoulder Muscles
☐ Thyroid trouble	☐ Pain in shoulders/arms	☐ Cancer	☐ Sleeping problems
☐ Twitching of eyes	☐ Painful/swollen joints	☐ Inner tension/Irritability	☐ Pins/needles in legs/feet

COMMENTS_____

_____

_____

List any medications or vitamins that you are taking: _____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

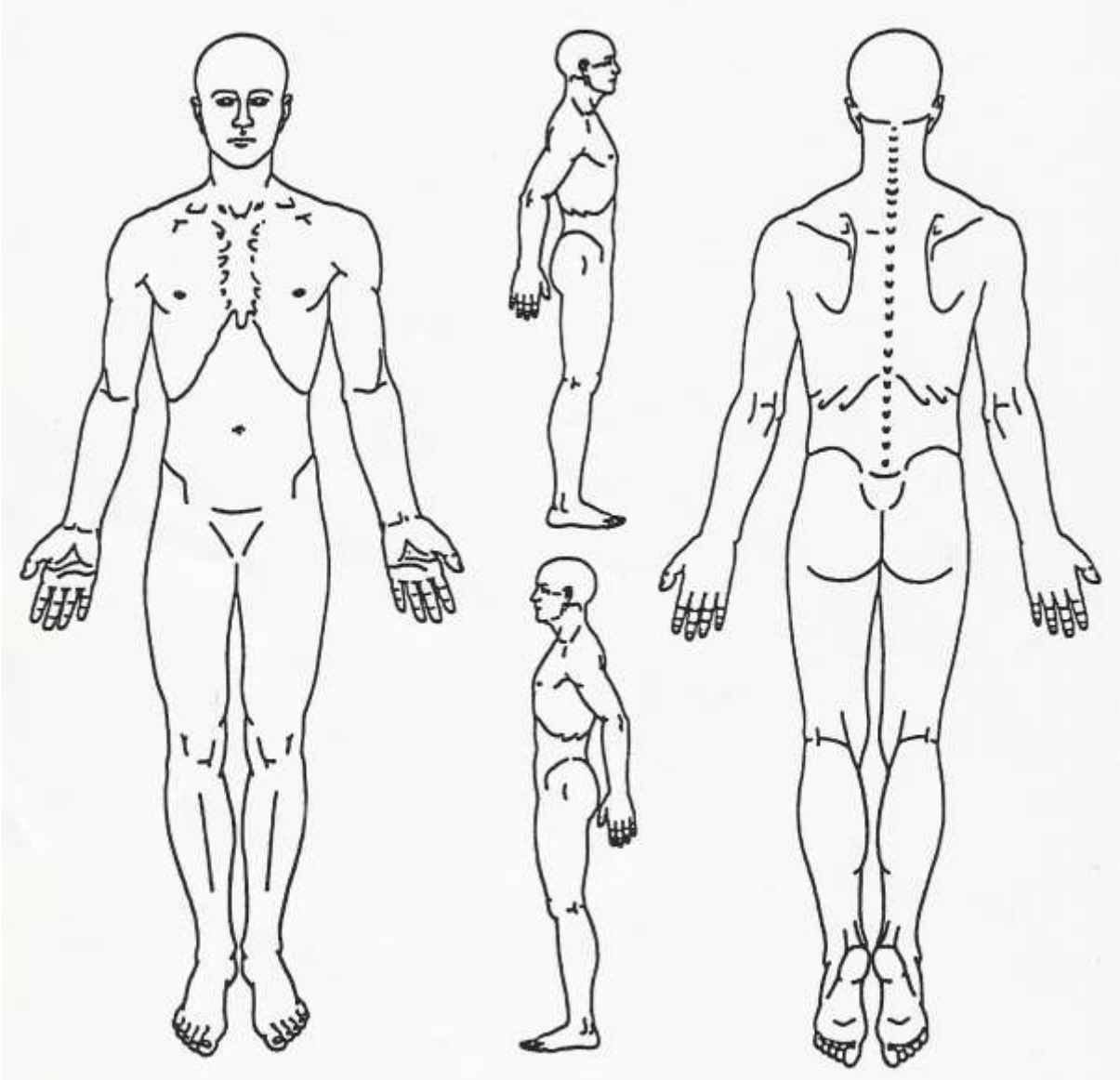
The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Date: _____

PAIN DRAWING- Include all affected areas

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain.

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



FOR EACH SYMPTOM: Please indicate **ON THE DIAGRAM ABOVE** how you would rate your **PAIN**:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worse pain ever)

FOR EACH SYMPTOM: Please indicate **ON THE DIAGRAM ABOVE** what percentage of the time you are awake do you experience the above symptom at the above intensity:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

FOR EACH SYMPTOM: Please indicate **ON THE DIAGRAM ABOVE** how long you have experienced these symptoms: Specify in Days, Weeks, Months or Years

PRINT NAME: _____

SIGNATURE: _____ DATE: _____