BROAD FAMILY CHIROPRACTIC

Please complete entire form
(Information required for Case History File)

PATIENT_____

HOME#_____ WORK#_____

ADDRESS_____

CITY_____ ST_____ ZIP_____

DATE OF BIRTH_____AGE_____

MARRIED_____SINGLE_____DIVORCED _____WIDOWED _____

SOCIAL SECURITY NUMBER_____

EMPLOYER_____

OCCUPATION_____

REFERRED BY: Patient referral (patient name)_____
Facebook/Twitter:____Yellow Pages:____ Lifetime Fitness:_____Google/Yahoo:_____
Other (please specify):_____

EMAIL ADDRESS:_____

DO YOU HAVE HEALTH INSURANCE? YES_____ NO_____
**IF YES, PLEASE GIVE YOUR INSURANCE CARD & DRIVER'S LICENSE TO FRONT DESK STAFF*

INSURANCE COMPANY_____
SUBSCRIBERS NAME_____
SUBSCRIBERS BIRTHDATE_____

PAYMENT IS EXPECTED AT TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE

CURRENT HEALTH CONDITION

Chief Complaint_____
Other Doctors Seen For This Condition _ Yes _ No` Who?_____
Type of Treatment:_____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? _ Yes _No
Is the Condition _ Job Related _ Auto Accident _ Home Injury _ Fall _ Other:_____
Date of Accident: _____ Time of Accident: _____
Have You Made a Report to Your Employer: _ Yes _ No
Drugs You Currently Take: _ Pain Killers/Muscle Relaxers _ Nerve Pills _ Blood Pressure Medicine _ Insulin _ Other:_____
Do You Wear a Shoe Lift? _ Yes _ No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____
_____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: _ Appendectomy _ Gall Bladder _ Hernia _ Cardiac Surgery _Disc Surgery _ Back/Neck Spinal Surgery _ Broken Bones Other_____
Major Accidents or Falls:

_____
_____

Hospitalization (Other Than Above):

Previous Chiropractic Care? Yes __ No __ Dr. Name, location, phone number and approximate date of last Visit?_____
_____

Do you have a primary physican? (MD or DO) Please list name, location, phone number and approximate date of last visit

_____
_____
_____

*Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect the overall course of care.

CHECK OFF ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

_ Pneumonia	_ Mumps	_ Influenza	_ Small Pox
_ Pleurisy	_ Polio	_ Chicken Pox	_ Arthritis
_ Tuberculosis	_ Diabetes	_ Epilepsy	_ Cancer
_ Mental Disorders	_ Heart disease	_ Anemia	_ Thyroid
_ Eczema	_ frequent colds/flu		

Have you ever tested positive for HIV _ Yes _ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL
_ Low Back Pain/stiffness
_ Mid Back pain/stiffness
_ Upper Back pain/stiffness
_ Neck Pain/stiffness
_ Jaw pain or clicking (TMJ)
_ Joint Pain/stiffness
_ Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
_ Shoulder pain
_ Hip pain
_ Foot trouble

NERVOUS SYSTEM
_ Numbness/tingling pain in buttocks, legs, feet, toes.
_ Paralysis
_ Trouble sleeping
_ Trouble concentrating
_ Under Stress
_ Tingling Extremities
_ ADD/ADHD
_ Seizures/Convulsions
_ Dizziness
_ Fainting
_ Depression
_ Breast pain/Lumps
_ Learning disability

GASTRO-INTESTINAL
_ Frequent Nausea
_ Liver Problems
_ Gall Bladder Problems
_ Weight trouble
_ Digestive problems
_ Eating disorder
_ Heart Burn
_ Constipation

GENITO-URINARY
_ Bladder Problems
_ Bed Wetting
_ Kidney problems

CARDIOVASCULAR
_ Stroke
_ Chest Pain
_ Blood Pressure Problems
_ Heart problems
_ Asthma

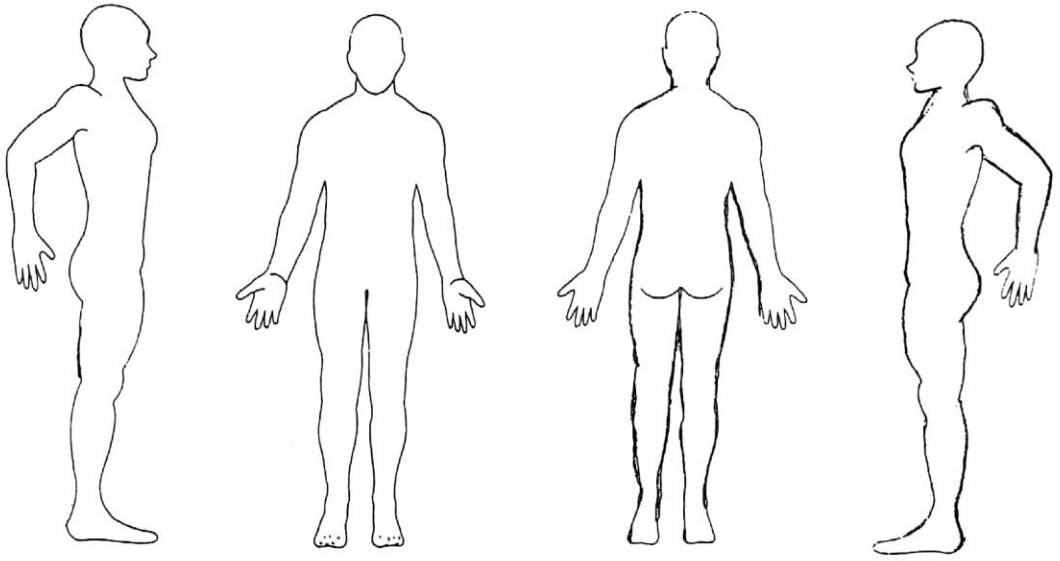
EARS, EYES, NOSE, THROAT
_ Vision Problems
_ Sore Throat
_ Ear Aches/infections
_ Ringing in ears
_ Hearing difficulty/loss
_ Allergies/ Sinus problems
_ Headaches

MALE/FEMALE
_ Prostate/sexual dysfunction
_ Menstrual Cramps
_Are you Pregnant now?_____

FAMILY HISTORY
The following members have a same or similar problem as I do:
_ Mother
_ Father
_ Brother
_ Sister
_ Child
_ Spouse

***Please put the appropriate symbol at the area/areas of you problems(s).

= = = Dull pain
X X X Sharp pain
+ + + Burning
0 0 0 Numbness/tingling



Right Front Back Left

CHIEF COMPLAINT QUESTIONAIRRE

1. Onset: When did this problem begin?_____
_____
2. Does anything make this problem better?_____
_____
3. Does anything make this problem worse?_____
_____
4. Rate your level of discomfort today: (no pain) 1--2--3--4--5--6--7--8--9--10 (severe pain)
5. When do you have pain in the area above (ie, all day, at night)?_____
_____

SECONDARY COMPLAINT QUESTIONAIRRE

1. Onset: When did this problem begin?_____
_____
2. Does anything make this problem better?_____
_____
3. Does anything make this problem worse?_____
_____
4. Rate your level of discomfort today: (no pain)1--2--3--4--5--6--7--8--9--10 (severe pain)
5. When do you have pain in the area above (ie, all day, at night)?_____
_____

** If additional complaints exist, doctor will consult.**

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

_ Relief _ Corrective _ Check here if you want the doctor to select the type of care appropriate for your condition.

_____ _____

Date Patient's Signature

Broad Family Chiropractic

TERMS OF ACCEPTANCE

-When a person seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

-Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

-**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

-**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

-**Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting ina lessening of the body's innate ability to express its maximum health potential.

-We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you, if you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

-Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of Broad Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, x-rays, adjustments, or any other procedure which is advisable, and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____have read, understand, and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature:_____(parent/guardian if minor) Date:_____

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PREGNANCY FORM

DATE:_____/_____/_____

By my signature on this form, I _____ do hereby state that, to the best of my knowledge, I am not PREGNANT, NEITHER suspected nor confirmed at this particular time.

Patient's signature:_____