Family Chiropractic & Massage of Charleston, Inc.

Patient Information

Name: (First, Middle, Last) _____

Preferred Name: _____ **Maiden Name** _____ **Date of Birth:** _____

Sex: ☐ M ☐ F ☐ Unspecified **Social Security #:** _____ **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address: _____ **(City, State, Zip)** _____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Home email: _____ **Work email:** _____

Employment Status (Check One) ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Race (Check One): ☐ White ☐ Black/African American ☐ American Indian/Alsakan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ I Choose Not to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Choose Not to Specify

Preferred Language) ☐ English ☐ Spanish ☐ American Sign Language ☐ Arabic ☐ Chinese ☐ Japanese ☐ Korean ☐ Portuguese ☐ Other _____

How Were You Referred to Our Office?

☐ By an Attorney ☐ By a Doctor/Insurance Plan ☐ By a Patient/Friend/Family/Employee ☐ Google ☐ Yelp ☐ Yellow Pages ☐ Other

Please print the name of who referred you: _____

Employment Information

Employer: _____ **Occupation:** _____

Address: _____ **(City, State, Zip)** _____

Responsible Party Information

Name _____ **Date of Birth:** _____

Address: _____ **(City, State, Zip)** _____

Social Security #: _____ **Responsible Party's Phone #:** _____ **Relationship to Patient:** _____

Occupation: _____ **Employer:** _____ **Employer Phone** _____

Insurance Information

Name of Insured: _____ **Relationship to Patient:** _____

Insured's Date of Birth: _____ **Social Security #:** _____ **Phone:** _____

Insurance Company: _____ **Group #:** _____ **ID Number:** _____

Address: _____ **(City, State, Zip):** _____

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____ Date of Accident _____

If Employment related, has employer been notified? ☐ Yes ☐ No **Employer Contact Name** _____

Employer Contact Phone and Extension: _____

Are you represented by an Attorney? ☐ Yes ☐ No **Attorney Name/Law Office:** _____

Completed by Office Staff

Height: _____ inches **Weight:** _____ pounds **BP:** _____ / _____ ☐ **HIPPA**

Past Health History

MEDICAL CONDITIONS Check all that Apply:

☐ Poor Circulation	☐ Heart Attack	☐ Stroke	☐ Seizures	☐ Headaches	☐ Joints Replacement
☐ Hypertension	☐ Chest Pain	☐ Bowel Problems	☐ Head Injury	☐ Joint Stiffness	☐ Osteoporosis
☐ Heart Disease	☐ Pace Maker	☐ Swelling of Legs	☐ Numbness	☐ Carpal Tunnel	☐ Broken Bones

Female: Are you pregnant at this time? ☐ No ☐ Yes **Due Date** _____

SURGERIES:

☐ Appendectomy	☐ Carpal Tunnel	☐ Cervical Spine	☐ Uro-genital	☐ Hernia
☐ Joint Replacement	☐ Prostate	☐ Thoracic Spine	☐ Hysterectomy	☐ Knee
☐ Brain	☐ Gastro-intestinal	☐ Lumbar Spine	☐ Gall Bladder	☐ Other: _____

FAMILY HISTORY:

	Parent	*Sibling*		*Parent*	*Sibling*		*Parent*	*Sibling*
Arthritis	☐	☐	Cancer	☐	☐	Psychiatric	☐	☐
Hypertension	☐	☐	Thyroid	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Heart Disease	☐	☐	Thyroid	☐	☐

SOCIAL HISTORY:

	Occasionally	*Often*	*Never*		*Occasionally*	*Often*	*Never*		*Occasionally*	*Often*	*Never*
Caffeine use	☐	☐	☐	Exercise	☐	☐	☐	Chew Tobacco	☐	☐	☐
Drink Alcohol	☐	☐	☐	Smoke Cigarettes	☐	☐	☐	Wear Seat Belts	☐	☐	☐

Chief Complaint

Describe your symptoms: _____

When did your symptoms start? _____ **Is this condition getting worse?** ☐ No ☐ Yes ☐ Constant ☐ Comes and Goes

How did your symptoms begin? _____

_____

How often do you experience your symptoms? (Circle the answer that best fits):

CONSTANTLY	FREQUENTLY	OCCASIONALLY	INTERMITTENTLY
76-100% of the day	51-75% of the day	26-50% of the day	0-25% of the day

What describes your pain symptoms? (Circle all that apply)

DULL SHARP THROBBING BURNING DEEP ACHING TINGLING
STABBING CRAMPING NUMBNESS RADIATING STIFFNESS

Symptoms are aggravated by: (Circle all that apply)

SITTING STANDING WALKING DRIVING SITTING TO STANDING LAYING DOWN

Have you had this, or similar condition, in the past? ☐ No ☐ Yes

If you received treatment in the past for the same or similar symptoms, who did you see?

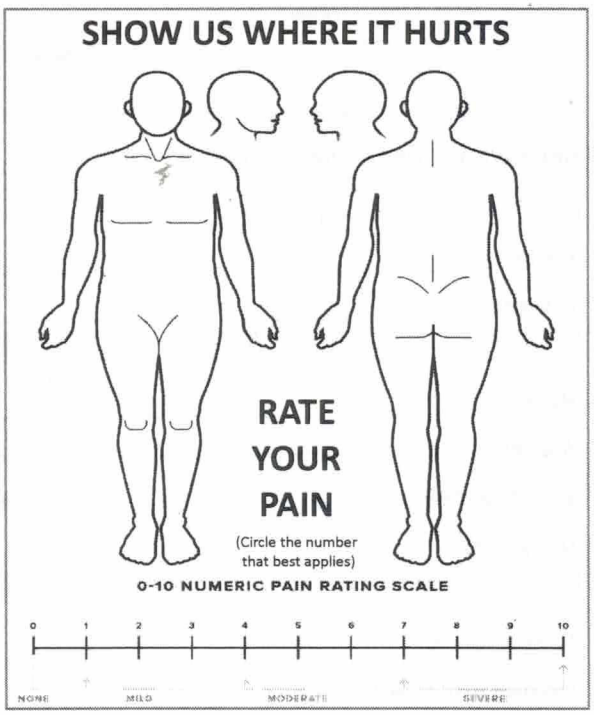
☐ This Office ☐ Other Chiropractor ☐ Medical Doctor

☐ Physical Therapist ☐ Other: _____

What tests have you had for your symptoms and when were they performed?

☐ X-Rays date: _____ ☐ CT Scan date _____

☐ MRI date: _____ ☐ Other date: _____



Informed Consent

I hereby request and consent to chiropractic adjustments by Family Chiropractic & Massage of Charleston, Inc. I understand and am informed that in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to 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 certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

Consent to treat a Minor (Minor's Printed Name): _____

Guardian or other Legally Authorized Person: _____ Date: _____