Welcome to One Family Chiropractic. To allow us to better serve you, and expedite your office visit, please fill out the form below to the best of your ability. If a section does not apply, simply write "N/A"

PERSONAL INFORMATION

Name _____Guardian (if under 18 years) _____
Date of Birth _____ Age _____ Social Security # _____
Address _____ City _____ State ___ Zip _____
Phone (H) _____ (W) _____ (C) _____ Cell Provider _____
E-mail _____ Occupation _____
Employer _____ Marital Status ❒ S ❒ M ❒ D ❒ W
Spouse's Name _____ Spouse's Occupation _____
How did you find out about OFC? _____
Emergency Contact: Name _____ Relationship _____ Phone _____

CHILDREN INFORMATION

Name _____ Age ____
Name _____ Age ____
Name _____ Age ____
Name _____ Age ____

PREVIOUS CHIROPRACTIC CARE?

Yes__ No__ Reason _____
Yes__ No__ Reason _____
Yes__ No__ Reason _____
Yes__ No__ Reason _____

HEALTH CARE PRACTITIONER HISTORY

Have you ever received chiropractic care? ❒ Yes ❒ No If so, name: _____
Reason for care _____ How long? _____ Date of last visit _____
How was your experience? _____
Have you every consulted or do you regularly consult with any of the following providers for you?
Check all that apply: ❒ Naturopath ❒ Acupuncturist ❒ Homeopath ❒ Energy Healer
❒ Psychotherapist ❒ Massage Therapist ❒ Other
Primary Physician Name _____ Date of last visit _____

REASON FOR SEEKING CHIROPRACTIC CARE

Do you have a present Complaint or Concern? If no current complaint, what is the reason for your visit today?
_____
When did this condition begin? _____
Is the condition: ❒ Getting Worse ❒ Improving ❒ Constant ❒ Intermittent ❒ Unsure
How did the condition start? ❒ Suddenly ❒ Gradually ❒ Post-Injury ❒ Auto Accident ❒ Other
What makes the condition better? _____
What makes the condition worse? _____
Is condition worse during certain times of the day? ❒ No ❒ Morning ❒ Afternoon ❒ Evening ❒ Night
Have you ever had a similar condition before? ❒ Yes ❒ No
If so, please explain _____
Is this condition interfering with: ❒ Work ❒ Sleep ❒ Daily Routine ❒ Hobbies ❒ Exercise ❒ Other
If so, please explain _____
Who have you seen for this condition? _____

Have you experienced or currently present with any of the following (Check all that apply):

- ❒ Asthma
- ❒ Allergies
- ❒ Anxiety or Nervousness
- ❒ Autoimmune Disease
- ❒ Blurred Vision
- ❒ Cancer
- ❒ Chest Pains
- ❒ Cold Feet or Hands
- ❒ Cold Sweats
- ❒ Constipation/Diarrhea
- ❒ Depression
- ❒ Diabetes
- ❒ Digestive Problems
- ❒ Dizziness
- ❒ Ears Ring
- ❒ Fainting
- ❒ Fatigue or Low Energy
- ❒ Gout
- ❒ Heart Burn
- ❒ Heart Problems
- ❒ Hernia
- ❒ High Blood Pressure
- ❒ Irregular Menstrual Cycle
- ❒ Irritability
- ❒ Kidney Stones
- ❒ Loss of Balance
- ❒ Loss of Memory
- ❒ Loss of Smell or Taste
- ❒ Numbness Fingers/Toes
- ❒ PMS
- ❒ Poor Posture
- ❒ Prostate Trouble
- ❒ Sensitive to Light
- ❒ Shortness of Breath
- ❒ Sleeping Problems
- ❒ Stomach Ulcer
- ❒ Stroke
- ❒ Tendonitis
- ❒ Thyroid Condition
- ❒ Urinary Frequency

Please list any prescription/over-the-counter drugs you are taking? _____

_____

Have you had surgery? ❒ Yes ❒ No

If so, please explain _____

If any, what side effects have you experienced from the drugs and surgery? _____

YOUR BIRTH PROCESS

What was YOUR birth process like? ❒ Vaginal ❒ Medications ❒ Forceps ❒ Caesarian ❒ Breach ❒ Episiotomy ❒ Epidural ❒ Induced ❒ Home or water birth ❒ Vacuum extraction ❒ Unknown ❒ Other: _____

CURRENT HEALTH HABITS

Chemical

Do you smoke? ❒ Yes ❒ No How often? ❒ Daily ❒ Weekends ❒ Occasional

Do you drink alcohol? ❒ Yes ❒ No How often? ❒ Daily ❒ Weekends ❒ Occasional

Do you presently consume any of the following?

❒ Artificial Sweetener ❒ Caffeine ❒ Dairy ❒ Gluten ❒ Processed Foods

Physical

Do you exercise? ❒ Yes ❒ No How often? ❒ 1-2x/week ❒ 3-4x/week ❒ 5x or more/week

Please list the type of exercise(s) _____

Have teeth problems? ❒ Yes ❒ No Have eye problems ❒ Yes ❒ No Have hearing problems ❒ Yes ❒ No

How many hours do you sleep a night? ❒ < 5 hours ❒ 5-7 hours ❒ 7-9 hours ❒ > 9 hours

How would you rate your current physical health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Emotional

Rate your current stress level regarding work ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ Very Low

Rate your current stress regarding finances ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ Very Low

Rate your current stress regarding relationships ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ Very Low

How would you rate your current mental/emotional health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Rate your current stress level overall ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ Very Low

How would you rate your overall quality of life? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

FEMALE HISTORY

Please list the number of: Pregnancies _____ Vaginal Deliveries _____ Cesarean Surgeries _____ Miscarriages _____

Deliveries Location ❒ Home ❒ Birth Center ❒ Hospital ❒ Other _____

Have you ever taken birth control medication? ❒ Yes ❒ No Have you ever had infertility issues? ❒ Yes ❒ No

Date of last menstrual cycle _____

MALE HISTORY

Have you ever experienced infertility issues? ❒ Yes ❒ No Date of last prostate exam _____

Erectile dysfunction? ❒ Yes ❒ No Difficulty/pain during urination? ❒ Yes ❒ No

FAMILY HISTORY

	Heart Disease	Arthritis	Cancer	Diabetes	Stroke
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Your oldest grandparent on record lived to the age of _____. ❒ Still living ❒ Deceased

EXPECTATIONS OF CARE

What are your personal and family's health goals?

_____

_____

How do you expect to achieve these goals?

_____

_____

Is there anything else you'd like to discuss with the Doctor today that you have not listed previously?

_____

_____

As a result of my chiropractic care, I would like to… (Please check all that apply)

- ❒ Feel better quickly
- ❒ Correct the cause of a problem as well as relief
- ❒ Prevent future problems
- ❒ Live a healthier lifestyle
- ❒ Healthier spine and nervous system
- ❒ Optimal health on all levels
- ❒ Other:_____

Thank you for trusting us.

One Family Chiropractic commits to the health and happiness of your life.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able 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 by 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 in a 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 evaluation, 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.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Patient's Name: (printed) _____

_____ _____
Signature Date

CONSENT TO CARE

I do hereby authorize the doctor of One Family Chiropractic to administer chiropractic care that is necessary for my particular case. This may include consultation, examination, 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 clearly understand that if I do not follow the doctors specific recommendations at One Family Chiropractic that I will not receive the full benefit from the services, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I understand that payment for care is out-of-pocket and paid before or directly after services are rendered. If I wish to obtain reimbursement from my health insurance company, One Family Chiropractic will supply the proper documentation necessary to receive reimbursement for services. One Family Chiropractic is not liable for any lack of reimbursement from my health insurance company.

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

Patient's Name: (printed) _____

_____ _____

Signature Date

HEALTHCARE AUTHORIZATION

The following authorizes One Family Chiropractic to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give permission to One Family Chiropractic to use my name, address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, health-related emails and information about treatment alternatives or other health related information, as well as advertisements, newsletters, or patient of the week/month postings.

I give permission to One Family Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during my treatment. Should I need to speak with a doctor in private, the doctor will provide a private room for these conversations.

By signing the following you are giving One Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

Patient's Name: (printed) _____

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I, _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges: 1) The right to review the notice prior to signing this consent 2) The right to object to the use of my health care information for directory purpose 3) The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Patient's Name: (printed) _____

_____ _____

Signature Date