FAMILYFIRST CHIROPRACTIC & ACUPUNCTURE

PATIENT PERSONAL INFORMATION

Last Name:	First Name:	M.I.	Today's Date:

Preferred Name:	Date of Birth:	SSN:	Gender: ☐Male ☐Female

Marital Status: ☐M ☐Sgl ☐Div ☐Sep ☐Wid	Spouse's Name:	Children's Names

Address 1:	Address 2:	City:	State:	Zip Code:

Mobile Phone:	Mobile Phone Carrier:	Home Phone:	Work Phone:

Email:	Who referred you to us? /How did you hear about us?

Occupation:	Employer:	Employer Address:

Emergency Contact:	Relationship to Patient:	Phone Number:	Phone Type: ☐Mobile ☐Work

Purpose of Appointment / Chief Complaints:

Approximate date symptoms began:

Circumstances that worsen symptoms:

Circumstances that alleviate symptoms:

If symptom is the result of an accident, what type of accident was it? ☐Auto ☐Work Related ☐Other:

Have you seen any other doctor for this condition? ☐Yes ☐No If yes, who?

Have you been treated by a doctor for ANY health condition in the last year? ☐Yes ☐No If yes, please describe below

INSURANCE INFORMATION: I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and I. Furthermore, I understand that *Family First Chiropractic & Acupuncture* will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

HIPPA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT): I authorize Family First Chiropractic & Acupuncture to use or disclose my health information in the manner described on the following forms:

- Consent for Use of Disclosure of Health Information
- Appointment Reminders and Health Care Information Authorization
- In-office Recognition/Correspondence by Mail/Fax/Electronic Communication
- North Carolina Chiropractic Association Authorization

I am also acknowledging that I may obtain a copy of the above listed authorizations/consents and I am also acknowledging that I may obtain a copy of the Informed Consent for Chiropractic Care.

Patient/Guardian Signature:	Date:

PATIENT HISTORY

FAMILYFIRST CHIROPRACTIC & ACUPUNCTURE

Name: _____

Please place check "✓" in the yes column for each condition that you are experiencing or have experienced in the past.

MUSCULO-SKELETAL	GASTROINTESTINAL	EYES/EARS/NOSE & THROAT	NERVOUS SYSTEM
❑ Low Back Pain	❑ Poor Appetite	❑ Eye Strain	❑ Numbness
❑ Mid Back Pain	❑ Excessive Hunger	❑ Eye Inflammation	❑ Loss of Feeling
❑ Pain Between Shoulders	❑ Difficulty Chewing	❑ Vision Problems	❑ Paralysis
❑ Neck Pain	❑ Difficulty Swallowing	❑ Ear/Nose/Jaw Pain	❑ Dizziness
❑ Arm Problems	❑ Excessive Thirst	❑ Noises in Ear	❑ Fainting
❑ Leg Problems	❑ Nausea	❑ Ear discharge	❑ Headaches
❑ Swollen Joints	❑ Vomiting Blood	❑ Hearing Loss	❑ Muscle Twitching
❑ Painful Joints	❑ Abdominal Pain	❑ Nose Bleeding/Discharge	❑ Convulsions
❑ Stiff Joints	❑ Diarrhea	❑ Difficulty Breathing (Nose)	❑ Forgetfulness
❑ Sore Muscles	❑ Constipation	❑ Sore Gums/Mouth	❑ Confusion
❑ Weak Muscles	❑ Black Stool	❑ Dental Problems	❑ Depression
❑ Walking Problems	❑ Bloody Stool	❑ Sore Throat or Hoarseness	❑ Insomnia
❑ Hip Pain	❑ Liver Problems	❑ Speech Problem	❑ Numbness
❑ Broken Bones	❑ Gall Bladder Problems	❑ Sinus Problems	❑ Loss of Feeling
❑ Shoulder Pain	❑ Weight Problems	❑ Allergies	❑ Paralysis

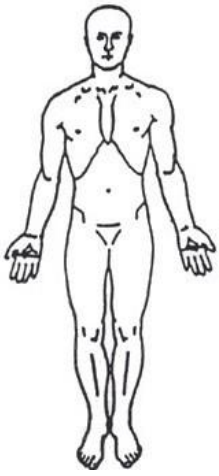
CARDIO & RESPIRATORY	GENITO-URINARY	HABITS	If yes, please describe use:
❑ Chest Pain	❑ Bladder Trouble	❑ Alcohol	
❑ Pain over Heart	❑ Excessive Urination	❑ Cigarettes/ Vape	
❑ Difficulty Breathing	❑ Scanty Urination	❑ Drug Abuse	
❑ Persistent Cough	❑ Painful Urination	❑ Chewing Tobacco	
❑ Coughing Phlegm	❑ Discolored Urination	❑ Caffeine	
❑ Coughing Blood	**[FEMALE]**	Please list any medications & describe surgeries if applicable:	
❑ Rapid Heartbeat	❑ Vaginal Discharge		
❑ Blood Pressure Issues	❑ Vaginal Bleeding		
❑ Poor Circulation	❑ Vaginal Pain		
❑ Heart Problems	❑ Breast Pain		
❑ Lung Problems	❑ Lumps on Breast		
❑ Varicose Veins	❑ Currently Pregnant		

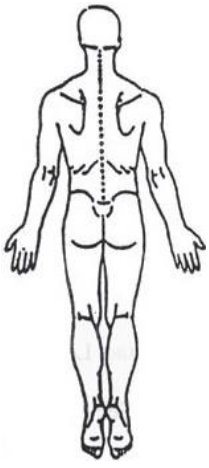
Mark the area of your primary symptom using the images below with the corresponding pain description letter below:

Aching **B**urning **D**ull Pain **N**umbness **P**ins & Needles **S**pasm **T**ender **O**ther_____

Please rate your pain on a scale of 1 to 10, with 10 being the worst: _____


Right


Front


Back


Left

Describe your symptoms in order of severity, starting with the first symptom.

1)_____ 2)_____

3)_____ 4)_____

FAMILYFIRST CHIROPRACTIC & ACUPUNCTURE

FINANCIAL POLICY

Insurance is an agreement between you and your insurance company; we are not a party to that contract. Our relationship is with you, not your insurance company. Our office staff will do their best to inform you of your plan benefits. **However, it is ultimately the financial guarantor's responsibility to be aware of the plan's benefits. This is including, but not limited to, deductibles, copays, pre-certifications and referrals.** We will file insurance claims on your behalf. All copayments/co-insurance amounts are due at the time services are rendered. All services/fees not payable by insurance are the fiscal responsibility of the guarantor. Patients with secondary insurance policies and/or health care reimbursement plans will be required to pay the copay/deductible of the primary insurance. Payments made by secondary carriers and/or health care reimbursement plans will be credited to your account upon our receipts of such payments(s).

Patients without insurance may pay in individual per visit fee or prepay for an office determined number of visits (Care Plan) at a reduced fee. Care Plans must be paid in full no later than the second visit or completed visits may be billed at the individual non-care plan per visit fee. Care Plan refunds for unused visits are calculated by multiplying the number of visits used by the individual non-care plan per visit fee, then subtracting the amount from the prepaid Care Plan fee. **Care Plan refunds are subject to a $50 administrative fee.** Care plan visits cannot be transferred to/from any account. Refunds for unused Care Plan visits must be requested by the patient. Payment is required at the time services are rendered.

Patients with worker's compensation and personal injury billing must notify our office of your injury claim at your initial visit including insurance contract information. If you do not inform our office of your injury claim, the potential exists that we will not file claims on your behalf or aid in legal matters. Any previous financial agreements are superseded when a legal injury claim occurs.

24-HOUR CANCELLATION POLICY

Due to an increased number of missed appointments, and limited room reservations, Family First Chiropractic & Acupuncture enforces a **24-hour cancellation policy for all massage and acupuncture appointments.** To reschedule your appointment, you must notify Family First Chiropractic & Acupuncture at 704.541.4747 as soon as possible to avoid being charged a **$50 fee** by credit card or invoice for the missed appointment. We appreciate your understanding, value your patronage, and will always do our best to accommodate your needs.

By my signature, I indicate that I have read the abovementioned policies and understand its content. I also understand that I am responsible for all fees associated with services rendered and I agree to its provisions and the party financially responsible.

Patient Name: _____

Signature: _____ Date: ____/_____/_____

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INFORMED CONSENT FORM

The nature of the chiropractic adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible pop or click, much as you have experienced when you crack your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment: As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Range of motion testing
- Orthopedic testing
- Basic neurological testing
- Muscle strength testing
- Postural analysis
- Electrical stim
- Ultrasound
- Hot/cold therapy
- Radiographic studies
- Mechanical traction
- Cold laser therapy

The material risks inherent in chiropractic adjustment: Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT OF PROFESSIONAL SERVICES: I hereby authorize and release Dr. Vicki Jordan and whomever she may designate to assist to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services deemed necessary in my case. I further authorize her to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient, family member, or employer of the patient for all or part of the clinic's charge, including, but not limited to, hospital or medical service companies, insurance carriers, workers compensation carriers, welfare funds, or the patient's employer.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name: _____

Signature: _____ Date: ____/_____/_____