FAMILYFIRST CHIROPRACTIC & ACUPUNCTURE

# PATIENT PERSONAL INFORMATION

| First Name: | Last Name: | Today's Date: |
|---|---|---|

| Height:<br>Weight: | DOB: | SSN: | Age |
|---|---|---|---|

| Address 1: | City: | State: | Zip Code: |
|---|---|---|---|

| Mobile Phone: | Mobile Carrier: | Home Phone: | Work Phone: |
|---|---|---|---|

| Email: | Occupation: |
|---|---|

How did you hear Family First Chiropractic & Acupuncture?

| Emergency Contact Name | Phone Number: |
|---|---|

Main Complaint(s):
1)
2)
3)

How long ago did this begin?

Have you consulted a physician?

Have you been given a diagnosis, if so, what:

What forms of treatment have you tried:

Past Medical History – Please circle all applicable to you:

| | | | | |
|---|---|---|---|---|
| Cancer | Diabetes | Hepatitis A, B, C | High Blood Pressure | Heart Disease |
| HIV | Seizures | Auto Immune | Thyroid Disease | Pace Maker |
| Depression | IBS | Hysterectomy | Kidney Disease | Prostate Issues |

Significant Trauma, auto accidents, injuries:

Surgeries and Dates

Other Significant Illness(es):

| Patient/Guardian Signature: | Date: |
|---|---|

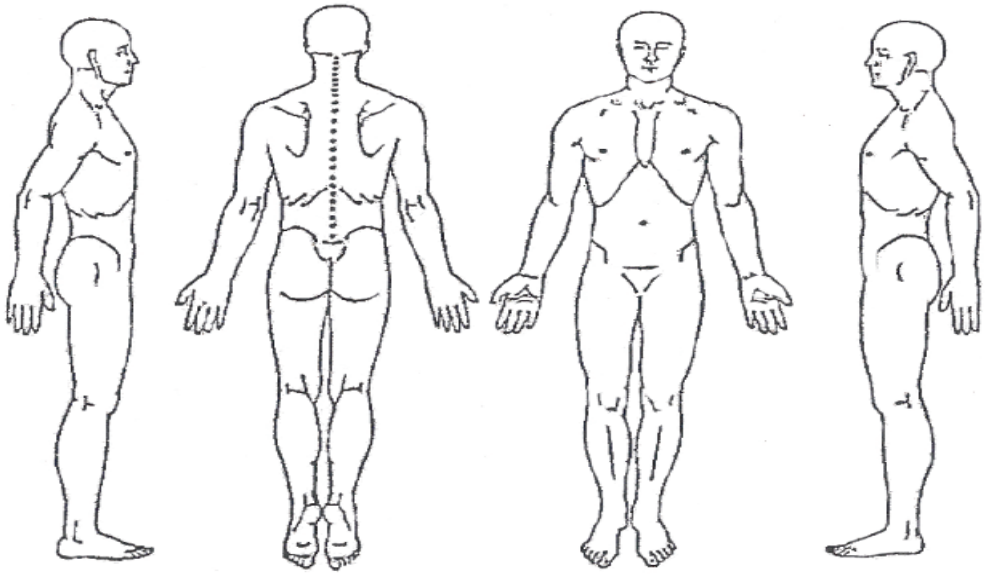
Medications:(include prescription, OTC, vitamins, herbs etc)

Do you currently take a multivitamin or antioxidant? Yes No

| Average Diet | | |
|---|---|---|
| Morning | Afternoon | Evening |
| | | |

Daily Health - Habits
Do you smoke? Yes No - If yes, how much?
How much soda do you drink in a week?
Do you drink Diet beverages?
Is more than 25% of your diet frozen, canned, boxed or processed foods? Yes No
How much water do you drink in a day?
How much coffee do you drink in a day?
How much alcohol do you drink in a week?
Describe how you feel about your appetite - Too Good Just Right Not Good Enough
Average number of hours of sleep per night?

Please indicate areas of pain



**General**

- [ ] Fevers
- [ ] Sweat Easily
- [ ] Night Sweats
- [ ] Running Warm
- [ ] Running Cold
- [ ] Strange Tastes or Smells
- [ ] Cravings
- [ ] Change in Appetite
- [ ] Weight Loss
- [ ] Weight Gain
- [ ] Poor Sleep
- [ ] Fatigue
- [ ] Sudden Energy Drop
- [ ] Cold Hands Feet
- [ ] Strong Thirst

**Skin and Hair**

- [ ] Rashes
- [ ] Itching
- [ ] Dandruff
- [ ] Dry Skin
- [ ] Brittle Nails
- [ ] Ulcerations
- [ ] Oozing Ulcers
- [ ] Eczema
- [ ] Psoriasis
- [ ] Hair Loss
- [ ] Hives
- [ ] Recent Moles
- [ ] Discoloration
- [ ] Infection
- [ ] Other:

**Head**

- [ ] Dizziness
- [ ] Vertigo
- [ ] Ringing in Ears
- [ ] Ear Blockage
- [ ] Facial Pain
- [ ] Teeth Grinding
- [ ] TMJ
- [ ] Cankersores - Mouth Ulcer
- [ ] Poor Vision
- [ ] Eye Tenderness
- [ ] Eye Twitching
- [ ] Eye Tearing
- [ ] Dry Eyes
- [ ] Spots/Floaters in Vision
- [ ] Poor Night vision
- [ ] Cataracts
- [ ] Migraines
- [ ] Tension Headaches
- [ ] Sinus Congestion
- [ ] Sore Throats
- [ ] Post Nasal Drip
- [ ] Nose Bleeds
- [ ] Cloudy Fogginess
- [ ] Concussion

**Cardiovascular**

- [ ] Chest Pain/Tightness
- [ ] Irregular Heartbeat
- [ ] High / Low Blood Pressure
- [ ] Fainting
- [ ] Cold Hands or Feet
- [ ] Swelling in Limbs
- [ ] Blood Clots
- [ ] Peripheral Artery Disease
- [ ] Varicose Veins

**Respiratory**

- [ ] Cough
- [ ] Coughing Blood
- [ ] Bronchitis
- [ ] Asthma
- [ ] Difficulty Breathing
- [ ] Wheezing
- [ ] Production of Phlegm
- [ ] Pneumonia
- [ ] Short of Breath

**Gastrointestinal**

- [ ] Nausea
- [ ] Vomiting
- [ ] Indigestion
- [ ] Acid Reflux
- [ ] Bloating
- [ ] Other:
- [ ] Gas
- [ ] Belching
- [ ] Diarrhea
- [ ] Constipation
- [ ] Sluggish Bowel
- [ ] Abdominal Pain - Cramps
- [ ] Rectal Pain - Burning
- [ ] Hemorrhoids
- [ ] Blood in Stool
- [ ] Undigested Food in Stool

**Urinary**

- [ ] Frequent Urination
- [ ] Urgency to Urinate
- [ ] Incontinence
- [ ] Dark Color to Urine
- [ ] Pain Upon Urination
- [ ] Blood in Urine
- [ ] Frequent UTIs
- [ ] Strong Odor to Urine
- [ ] Inability to Empty Bladder
- [ ] Weak Stream
- [ ] Kidney Stones
- [ ] Frequent Night Urination

**Male Health**

- [ ] Impotence
- [ ] Premature Ejaculation
- [ ] Enlarged Prostate
- [ ] Low Sperm Count
- [ ] Low Motility
- [ ] Testicular Pain
- [ ] Low Libido
- [ ] STDs
- [ ] Other:

**Female Health**

Are you or is it possible that you're pregnant:
# of Live Births:
# of Miscarriages:

Age of first period:
Days between Day 1 of period:
Using Birth Control:

Duration of Period:

- [ ] Heavy Period
- [ ] Light/Scanty Period
- [ ] Painful Period
- [ ] Breast Tenderness
- [ ] Period begins with spotting
- [ ] Uterine Fibroids
- [ ] Ovarian Cysts
- [ ] Endomitriosis
- [ ] Clots in Blood Flow
- [ ] PMS
- [ ] Vaginal Discharge
- [ ] Frequent Yeast Infections
- [ ] STDs
- [ ] Infertility Issues
- [ ] Spotting During Ovulation

**Musculoskeletal**

- [ ] Neck Pain
- [ ] Shoulder Pain
- [ ] Back Pain
- [ ] Sciatica
- [ ] Hand / Wrist Pain
- [ ] Foot / Ankle Pain
- [ ] Hip Pain
- [ ] Knee Pain
- [ ] Overall Muscle Achiness
- [ ] Muscle Weakness
- [ ] Herniated Discs
- [ ] Other:

**Neurological**

- [ ] Seizures
- [ ] Stroke
- [ ] Concussion
- [ ] Other:
- [ ] Dizziness / Vertigo
- [ ] Loss of Balance
- [ ] Confusion
- [ ] Areas of Numbness
- [ ] Tremors
- [ ] Neuropathy - Nerve Pain

**Emotions**

- [ ] Depression
- [ ] Anxiety
- [ ] Anger
- [ ] Insomnia - mind racing
- [ ] Fearful
- [ ] Phobias
- [ ] Panic Attacks
- [ ] Cloudy Foggy Mind
- [ ] Other:

Are you currently being treated for emotional or psychological issues:

Have you ever considered or attempted suicide?

FAMILYFIRST CHIROPRACTIC & ACUPUNCTURE

# 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 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.

# 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.

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: ____/_____/_____