



Date: \_\_\_\_\_

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ Cell Provider (*for text reminders*): \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Guardian Name: \_\_\_\_\_

Marital Status: S M D W O Spouse's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Children's Names/Age: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**How Did You Hear About Us?:** \_\_\_\_\_ Hobbies: \_\_\_\_\_

Name of Previous Chiropractors: \_\_\_\_\_

When was your last visit: \_\_\_\_\_ How long were you receiving chiropractic adjustments: \_\_\_\_\_

**Reason for coming in:** \_\_\_\_\_

**INJURIES:**

What accidents have you had (ex. bicycle, car, motorcycle, sports, slips/falls) at work or at home?

Include dates: \_\_\_\_\_

Were you ever knocked unconscious? YES NO

What fractures or broken bones have you had? Include dates: \_\_\_\_\_

**SURGERY:**

What major surgery have you had? Include dates: \_\_\_\_\_

What minor surgery have you had? (Tonsillectomy, appendectomy, wart/cyst removal, dental extr.)

**MEDICATION:**

Present Prescription drugs

Past prescription drugs

Over-the counter drugs

(aspirin, cold tablets, cough syrup)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THERAPY:**

Are you presently under any therapeutic care? \_\_\_\_\_ What type? \_\_\_\_\_

What therapeutic care have you been under in the past two years? (radio, chemo, physio, electro, etc. )

Include Dates: \_\_\_\_\_

**BIRTH RECORD:**

Type of birth (vaginal, cesarean, forceps, etc.) \_\_\_\_\_

Complications during your mother’s pregnancy or during birth: \_\_\_\_\_

Complications after your birth: \_\_\_\_\_

**CURRENT HEALTH:**

How do you describe your current health: \_\_\_\_\_

How would you describe your family’s health: \_\_\_\_\_

Describe your: Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_ Coordination: \_\_\_\_\_

Do you use any of the following: TOBACCO ALCOHOL COFFEE/TEA SODA MILK

Level of stress in your life: MILD MODERATE EXTREME Rating of stress: 1 2 3 4 5 6 7 8 9 10

Do you purchase any of the following?

\_\_\_\_Bottled drinking water \_\_\_\_Vitamins \_\_\_\_Health food products (organic products etc.)

**FINANCIAL INFORMATION:**

Who is responsible for this account? SELF SPOUSE OTHER Name if other: \_\_\_\_\_

What method of payment will you be using? INSURANCE CASH CHECK CREDIT CARD

**Please check any of the following that give you difficulty or you had had recently**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Numb legs/feet         |
| <input type="checkbox"/> Shooting head pains    | <input type="checkbox"/> Loss of balance         | <input type="checkbox"/> Mid-back pain        | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Sinus trouble          | <input type="checkbox"/> Ringing in ears         | <input type="checkbox"/> Heart attack         | <input type="checkbox"/> Kidney trouble         |
| <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Blurred vision          | <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> Menstrual cramps       |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Lights bother eyes      | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Hayfever               | <input type="checkbox"/> Neck pain               | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Muscle spasms in neck   | <input type="checkbox"/> Nerves/nervousness   | <input type="checkbox"/> Painful joints         |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Shldr/arm tightness     | <input type="checkbox"/> Inner tension        | <input type="checkbox"/> Swollen joints         |
| <input type="checkbox"/> Thyroid trouble        | <input type="checkbox"/> Shldr/arm pain          | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Pins & needles in leg  |
| <input type="checkbox"/> Facial twitch          | <input type="checkbox"/> Pins & needles in arms  | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen ankles         |
| <input type="checkbox"/> Loss of memory         | <input type="checkbox"/> Pins & needles in hands | <input type="checkbox"/> Indigestion          | <input type="checkbox"/> Cold Feet              |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Cold Hands              | <input type="checkbox"/> Intestinal gas       | <input type="checkbox"/> Pain in legs/feet      |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Numbness in arms/hands  | <input type="checkbox"/> Low back pain        | <input type="checkbox"/> Hip pain               |
| <input type="checkbox"/> Spinal curvature       | <input type="checkbox"/> Prostate trouble        | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Jaw pain/TMJ           |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Bed wetting             | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Ulcers                 |
| <input type="checkbox"/> Ear ache               | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Seizures             |   |



## PREGNANCY HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Estimated Due Date: \_\_\_\_\_ How many weeks gestation is your baby? \_\_\_\_\_

Intended Delivery (circle): HOME HOSPITAL \_\_\_\_\_ OTHER \_\_\_\_\_

Who is your Midwife/OB: \_\_\_\_\_ Phone#: \_\_\_\_\_

The reason for this visit is a result of

- |  |   |                                      |                                      |
|--|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Breech Presentation | <input type="checkbox"/> Pregnancy Related Backache | <input type="checkbox"/> Headache    | <input type="checkbox"/> Trauma      |
| <input type="checkbox"/> Chronic Condition   | <input type="checkbox"/> Nausea                     | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Other _____ |

How many pregnancies have you had? \_\_\_\_\_ Vaginal Deliveries \_\_\_\_\_ Cesarean Surgery \_\_\_\_\_

Please explain any complications with this or past pregnancies \_\_\_\_\_

### Have you ever suffered from...

- |                     |   |   |                                     |
|---------------------|---|---|-------------------------------------|
| Dizziness           | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Backaches           | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Water Retention     | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Diabetes            | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| High Blood Pressure | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Headaches           | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Asthma              | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Stomach Trouble     | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Sinus Trouble       | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Neck Pain           | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |
| Other               | <input type="checkbox"/> Before Pregnancy | <input type="checkbox"/> During Pregnancy | <input type="checkbox"/> Postpartum |



### TERMS OF ACCEPTANCE

If a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us 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 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 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 Ferguson Family Chiropractic to administer such 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 understand any sum of money paid under assignment by any insurance shall be credited to my account, and 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: \_\_\_\_\_  
Signature of parent or guardian if minor

Date: \_\_\_\_\_



## HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request a copy if you would like one.

This Notice of Privacy Practice also describes my rights and duties of the chiropractor with respect to my Protected Health Information. I hereby give permission to Ferguson Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following.

### SPECIFIC AUTHORIZATIONS

- I give permission to FFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If FFC contacts me by phone, I give them the permissions to leave a phone message on my answering machine or voice mail.
- I give permission to FC to use my name on a welcome board, referral board and birthday board.
- I give permission to FFC to use my photograph on the patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on the their website or in ads in print media.
- I give FFC permission 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 protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance you access to quality health care and health information. This authorization will remain in effect for the duration of my care at FFC plus 7 years or until revoked by me.



### RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action to reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of FFC. The written notice must contain the following information:

- Your name, Social Security number & date of birth;
- A clear statement of you intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. (Minimum necessary standards apply)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or cop, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

### HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

My Name (please print): \_\_\_\_\_

My Signature: \_\_\_\_\_

Today's date: \_\_\_\_\_

#### **Name of personal Representative (if someone is designated to act on your behalf)**

Name (please print): \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

Description of Representative's Authority to Act on Patients Behalf: \_\_\_\_\_