FERGUSON FAMILY CHIROPRACTIC HEALTH HISTORY FORM

Today's Date_____

PERSONAL DATA

Name _____ Date of Birth _____

Height _____ Weight _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Cell Phone (____) _____

E-mail address_____@_____

Occupation _____ Employer _____

Names and Ages of Children_____

Emergency Contact/ relationship _____

Whom may we thank for referring you to our office? _____

Would you like to sign up for are email newsletter that is sent monthly? ____YES ____NO

Would you be interested in signing a release to be featured on our social media? ____ YES ____ NO

REASON FOR SEEKING CHIROPRACTIC CARE

What are your top health concerns you feel Ferguson Family Chiropractic can address for you?

_____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ☐Y ☐N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

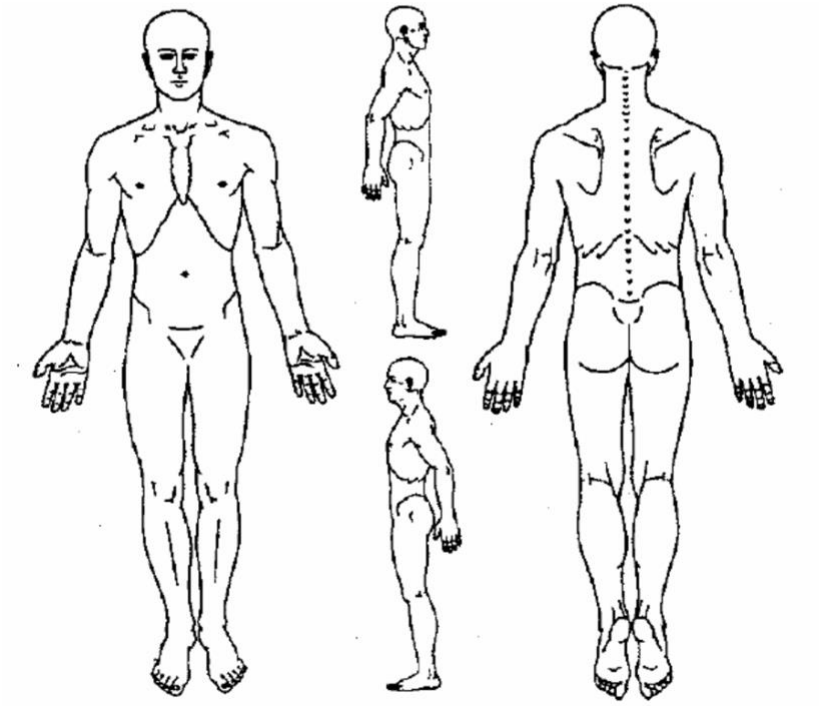
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason: _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



PHYSICAL STRESS:

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how YOU were birthed. (If you do not know, please skip to next question)

☐ Home ☐ Natural ☐ Hospital ☐ Caesarian section ☐ Forceps
☐ Breech ☐ Cord around neck ☐ Prolonged labor ☐ Drug induced labor ☐ Suction

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.
Please list the major traumas that you remember from your childhood up to the present._____
_____

Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:
_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? Y ○ N ○
If yes, list body parts injured and dates of injuries:
_____

Have you ever been hospitalized or had surgery? Y ○ N ○

If yes, state reason and dates: _____

Are you pregnant? Y ○ N ○ Date of last menstrual period: _____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife_____

EMOTIONAL STRESS:

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	Y ○ N ○	Loss of loved one	Y ○ N ○	Abuse	Y ○ N ○
Work or School	Y ○ N ○	Divorce/separation	Y ○ N ○	Financial	Y ○ N ○
Lifestyle change	Y ○ N ○	Parents divorce	Y ○ N ○	Illness	Y ○ N ○

CHEMICAL STRESS:

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? Y ○ N ○ If yes, did you have a reaction? Y ○ N ○ Unsure ○

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

☐ Toxic chemicals ☐ Second hand smoke ☐ Drug therapy

☐ Radiation ☐ Chemotherapy ☐ Other

Do you have allergies or sensitivities to any foods? Y ☐ N ☐ If yes, please list:

_____

Do you presently consume any of the following?

☐ Coffee/caffeine ☐ Alcohol ☐ Tobacco ☐ Over the counter drugs ☐ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

QUALITY OF LIFE (presently)

How do you grade your physical health?	☐ Good	☐ Fair	☐ Poor
How do you grade your emotional/mental health?	☐ Good	☐ Fair	☐ Poor
How do you rate your overall “quality of life”?	☐ Good	☐ Fair	☐ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Relief and Prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels
- ❒ Weight Loss

Financial Agreement:

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to provide excellent service to you. Payment is due at time service is rendered. You will be responsible for the fees for all services you receive.

- Should you discontinue care at any time you are still responsible for outstanding bills/charges.
- If you are on a payment plan, you will be responsible for the outstanding balance for care you have already received, and have not fully paid for.
- I am responsible for any amounts not covered by my insurance.

Time of Service Discount Options (TOS)	$115
TOS Re-exam	$ 55
TOS Medicare Exam	$60
TOS Spinal Adjustment	$45
TOS Kinesio Therapy	$15
TOS EMS, Ultrasound, ART	$12

****We also offer family plans for patients and their family and visit bundle discounts! Please ask for more details****

INSURANCE INFORMATION

☐ **Insurance**

Insurance coverage varies greatly. We will verify chiropractic coverage specific to your plan and estimate what will be due. Payment must be made each visit for services not covered or patient responsibility amount. This is not a guarantee but only an estimate of charges not covered. Additional charges may apply based on your insurance coverage.

☐ **Personal Pay**

Most of our patients pay for care "out of pocket", even those with insurance reimbursement plans. Our discounted time of service plans allow you to receive all the care necessary for you to regain your health at an affordable fee. We will be happy to provide you with monthly statements for insurance reimbursement.

☐ **Medicare**

Medicare pays for a portion of chiropractic care; exams and therapy (electrical stim, ultrasound, and ART-muscle work) are not covered services under any Medicare and secondary policy. **Patients are responsible for exam- $60.00 and Therapy - $12.00 per therapy.**

☐ **Personal Injury/accident, Worker's Compensation Insurance**

If you have an auto accident, a worker's compensation injury a personal injury (or other insurance that requires direct billing) you will be expected to complete all the paperwork necessary for us to file the claim on your behalf. If paperwork is not completed within the first week of care, you will be expected to pay for your chiropractic care.

☐ PIP forms filled out. Date of Accident_____

☐ Injury reported to Employer. Date of Injury_____

TERMS AND CONSENT TO CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective as this prevents any confusion or disappointment.

The objective of chiropractic health care in this office is to *improve and optimize the health and function of the spine and nerve system through the correction of Vertebral Subluxation*[i]. A Chiropractic Adjustment is the method used for the correction of Vertebral Subluxations.

We do not diagnose or treat disease. We analyze the spine for Vertebral Subluxations. 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.

Our commitment to your health is to (1) evaluate and monitor your spine and nerve system on each visit to determine the adjustment and adjusting procedures that will get the best outcome for you and (2) to provide you with supportive education and information so you can make the best health choices.

I will receive a report of findings which includes the doctor's objectives, recommendations, expectations and options relative to my care in this office. Once informed of treatment I will receive care on this basis.

The information I have provided on this case history form is true and accurate to the best of my knowledge.I give Dr. Brian Ferguson, Dr. Amanda Ferguson, Dr. Peter Ferguson, Dr. Emily Rehm, Dr. LaRissa Tilley and Dr. Nate Betts permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____Date: _____

Signature: _____

Signature of Parent (for minor):_____ Date: _____

***We kindly ask that if you need to reschedule or cancel your appointment that you give at least 24 hours notice. Thank you for understanding that our time is valuable.**

Thank you for choosing Ferguson Family Chiropractic.
We look forward to helping you.