familyfirst CHIROPRACTIC

A Total Wellness Center

Last Name:

800 Hwy 290 W./Building F
Dripping Springs, TX 78620
(512)-858-9355
www.ffchiro.com

Welcome To Family First Chiropractic!

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with your examination procedures, which will determine if we can help you, we want you to understand what we do and why we are going to do it.

When a person seeks our care and when we accept a patient for such care, it is essential that they are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do it in our office.

We provide various services in our office including Chiropractic care, massage therapy, exercise therapy and nutritional services. The purpose of Chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine call vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interference (pinched nerve) and cause dysfunction to the tissue and organs that these nerves supply. With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

The information we get from you on the following pages is important. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

I, _____, have read the above, understand it.

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Last Name:

Date: _____ Social Security #_____

Name: _____
Last First M.I

Address_____City_____ST_____Zip_____

E-mail (please provide for communication purposes) _____

Cell Phone:_____ Home Phone: _____

Sex: _____Male _____ Female Age:_____ Birthdate:_____

___Married ____Separated ____Widowed ____Divorced ____Single ____Partnered for ___Yrs ____Minor

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name _____ Phone _____

Race (Circle): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Patient Employer/School _____

Address:_____

Phone: _____ Occupation:_____

Spouse's Name:_____ SS#_____ - _____ - _____ Phone:_____

Birthdate:_____ Spouse's Employer: _____

Emergency Contact:_____ Relationship:_____ Phone_____

ACCIDENT INFORMATION: Is condition due to an accident? Yes____ No____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home____ Other ____

INSURANCE INFORMATION:
Who is responsible for this account? _____ Relationship to patient:_____

Insurance Co:_____ ID#_____

Subscriber Name _____ Birthdate:_____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Drs. Chae and Monya Tracy, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____
Please print name of above signature Relationship to Patient

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Financial Responsibility

Patient Name_____

Dear Patient,
Family First Chiropractic provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.
I have read and understood all the above information.

_____ _____
Patient Signature Date

X-Ray Consent

I hereby give my consent to Family First Chiropractic and its representatives to take x-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

_____ _____
Patient Signature Date

Clinical Summary (a required EMR question)

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

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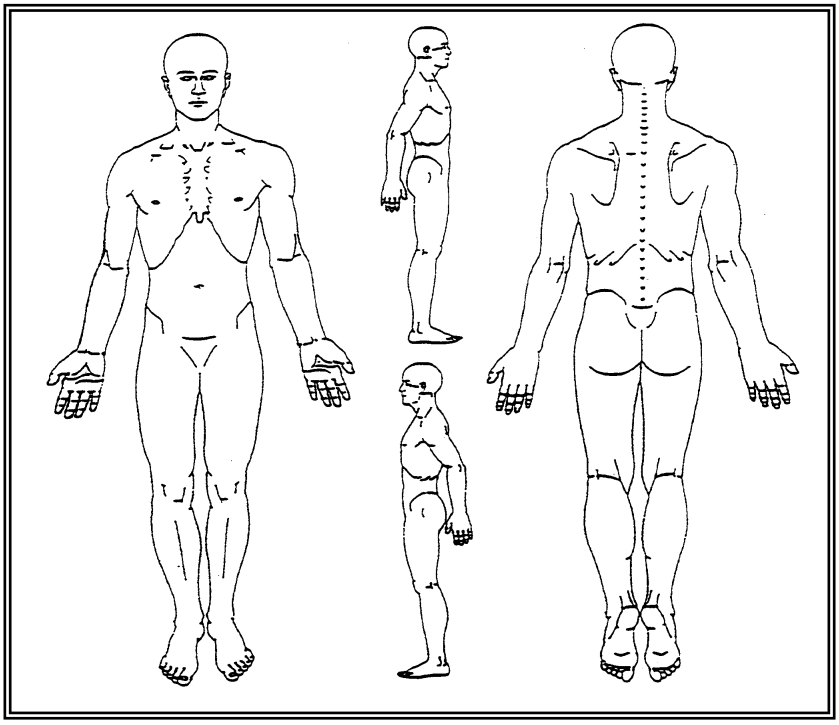
Please let us know who we can thank for referring you to our office: _____

Please indicate the main reason you are seeing us today: _____

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Do you have any other health conditions, regardless of whether you think it's related to your spine:

_____

_____

_____

Is there any radiating pain into the arms or legs? _____ Is there any numbness or tingling? _____

How long have you been suffering with this problem, has it been more than a month or two? _____

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When was the first time you EVER recall having a problem in this area? _____

How often have you suffering with this problem? (Please indicate for each of the body area of concern)

Constant (75 – 100% of the time) _____Frequent (50 – 75% of the time)_____

Occasional (25 – 50% of the time) _____ Intermittent (0 – 25% of the time) _____

Every trauma is recorded in the spine. Please give a brief description of any significant injuries or accidents over the course of your life (slips, falls, injuries, car accidents) , whether or not you think they are related to your spine:

_____

_____

_____

Did you go to the hospital for any of these injuries? _____

Did you get any X-rays for any of these injuries? _____

Did you get checked by a Chiropractor after any of these injuries?_____

List any MD's or Chiropractors you've already seen for your current problem:

_____

What do you do most of the day in your job postures, positions and repetitive movements:_____

_____

What tests have you already had for this problem? ☐X-rays ☐MRI ☐C.T. Scan ☐Myelogram ☐EMG/NCV
☐None ☐Other _____

What have you already tried for this problem? ☐Anti-inflammatory ☐Pain Meds ☐Muscle Relaxers
☐Injections ☐Physical Therapy ☐Chiropractic ☐Massage ☐Exercise ☐Other _____

What makes your problem <u>worse</u>? ☐Sitting ☐Standing ☐Changing Position ☐Walking ☐Bending ☐Lifting ☐Twisting
☐Reaching ☐Driving ☐Sleeping ☐Sneeze/Cough ☐Computer Work ☐Telephone ☐Going From Sit to Stand
☐Other_____

What activity does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again? _____

What area of your life has this problem affected the most? ☐Family ☐Relationships ☐Work ☐Exercise ☐Recreation

_____

On a scale of 1 to 10, with 10 being the highest, rate your level of commitment to get rid of this problem: _____

Please list any concerns you may have about getting this problem corrected such as time or transportation:

_____

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PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

_____

Please list any surgeries you have had over the course of your life: _____

_____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? ☐Yes ☐No **If yes, please list:** _____

List any medications you are taking: _____

_____

FAMILY HISTORY

Mother: ☐Living ☐Deceased List any medical problems: _____

Father: ☐Living ☐Deceased List any medical problems: _____

List any problems common in your family: ☐Cancer ☐Diabetes ☐Heart disease ☐High blood pressure ☐Stroke ☐Arthritis ☐Scoliosis ☐Thyroid disease ☐Osteoporosis ☐ Other _____

SOCIAL HISTORY

Do you have any children? ☐Yes ☐No If yes, how many? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much & how often? _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

PERSONAL HEALTH GOALS

☐Improve Nutrition/Eating Habits	☐Lower Cholesterol	☐Get off Medications
☐Weight Loss/Fat Loss	☐Lower Blood Pressure	☐Improved Sleep
☐Increase Lean Muscle Mass	☐Start Exercising	☐Improved Energy
☐Increase Bone Density	☐Look Better	☐Improved Posture
☐Reduce Stress	☐Feel Better	☐Improved Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:

Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____

Do you take: Omega 3 (Fish Oil)? Yes No Vitamin D3? Yes No Probiotics? Yes No

Who is your Family Physician or Primary Doctor that monitors you? _____

When was the last time you had blood work done? _____

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Functional Rating Index

For use with neck and/or back problems. For each item below, please circle the number which most closely describes your condition right now.

Patient Name _____ Date_____

1. Pain Intensity

0- No Pain	**1-** Mild Pain	**2-** Moderate Pain	**3-** Severe Pain	**4-** Worst Possible Pain

2. Sleeping

0- Perfect Sleep	**1-** Mildly Disturbed	**2-** Moderately Disturbed	**3-** Greatly Disturbed	**4-** Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0- No Pain No Restrictions	**1-** Mild Pain; No Restrictions	**2-** Moderate Pain; Go Slowly	**3-** Moderate Pain; Some Assistance	**4-** Severe Pain; 100% Assistance

4. Travel (driving, etc.)

0- No Pain on Long Trips	**1-** Mild Pain on Long Trips	**2-** Moderate Pain on Long Trips	**3-** Moderate Pain on Short Trips	**4-** Severe Pain on Short Trips

5. Work

0- Usual Work + Extra	**1-** Usual Work, No Extra	**2-** 50% of Usual Work	**3-** 25% of Usual Work	**4-** Cannot Work

6. Recreation

0- All Activities	**1-** Most Activities	**2-** Some Activities	**3-** Few Activities	**4-** No Activities

7. Frequency of Pain

0- No Pain	**1-** Occasional (25%)	**2-** Intermittent (50%)	**3-** Frequent (75%)	**4-** Constant (100%)

8. Lifting

0- No Pain with Heavy Weight	**1-** Increased Pain with Heavy Weight	**2-** Increased Pain with Moderate Weight	**3-** Increased Pain with Light Weight	**4-** Increased Pain with Any Weight

9. Walking

0- No Pain with Any Distance	**1-** Increased Pain after 1 Mile	**2-** Increased Pain after ½ Mile	**3-** Increased Pain after ¼ Mile	**4-** Increased Pain after Any Distance

10. Standing

0- No Pain with Any Time	**1-** Increased Pain after Several Hours	**2-** Increased Pain after 1 Hour	**3-** Increased Pain after ½ Hour	**4-** Increased Pain after Any Time

Total _____ (/4, X10) = Functional Rating Score _____%