APPLICATION FOR CARE AT FAMILY FIRST WELLNESS CENTER

Today's Date: __________________ HRN: _________________________

PATIENT DEMOGRAPHICS (Please Print)

Name: ____ Birth Date: _____-_____-____ Age: _______ ☐ Male ☐ Female

Address: ____ City: _____________ State: _______ Zip: __________________

E-mail Address: _______________________________ Phone Mobile: _______________ Phone H/ W: ________________

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ No ☐ Yes Insurance Type: ______________________

Employer: ___________________________________ Occupation: ____

Spouse's Name: ________________________________ Spouse's Employer: _____________________________________

Height:_____________ Weight:__________ Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I Decline to answer

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

Preferred Language: English Spanish, French, Italian, Creole, Other:____________________

Emergency Contact Name: _______________________ Phone Number: _________________ Relationship: _______________

Who referred you to this office? ____________________________________

Are you here for wellness care? ☐ No ☐ Yes If yes, please skip to **PAST HISTORY – Complaint or Wellness** on Page 2.

Goals For My Care: People see health care practitioners for a variety of reasons. Some seek to correct whatever core malfunctions they may be experiencing, some for relief of pain or discomfort, and some to correct the cause of pain or discomfort. Dr. Haskel will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we can create a personalized program.

☐**Relief Care -** Symptomatic relief of pain or discomfort
☐**Corrective Care -** Correcting and relieving the cause of the problem as well as the symptoms
☐**Comprehensive Care -** Address the entire system and bring whatever is malfunctioning in the body to the highest state of health possible.
☐**Other Goals -** ☐ Weight Loss ☐ Increased Energy ☐ Hormone Balance ☐ Other_____________________________________

On a scale of **1** to **10** with **10** being the worst discomfort and **zero** being no discomfort, rate your health concerns by ***circling the number***:

Primary or chief complaint is____ : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? __________ Is it the result of ANY type of accident or injury? ☐ Yes, ☐ No

If so, please describe it: ____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

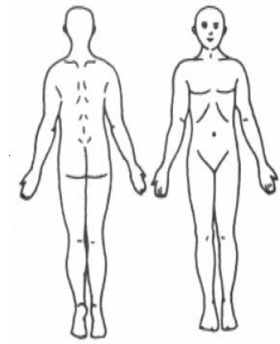
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐It comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes **If yes,** when? ________ by whom? _________________

How long were you under care? _______________ What were the results? ____

Name of Previous Chiropractor: ____ ☐**N/A**

Second complaint___________________________________ :0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint ___________________________________ :0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint ___________________________________ :0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling

What relieves your symptoms? ____

What makes them feel worse? ____

IDENTIFY ANY OTHER INJURY(S) TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:

____
____
____
____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:		EFFECT:		
Carrying Groceries	☐ No Effect	☐Painful (can do)	☐Painful (limits)	☐ Unable to Perform
Sit to Stand	☐No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Driving	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Extended Computer Use	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Household Chores	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Lifting Children	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Reading/Concentration	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Bathing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Dressing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Shaving	☐No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sleep	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Static Sitting	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Static Standing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Yard work	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Walking	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sweeping/Vacuuming	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Dishes	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Laundry	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Garbage	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Lifting Groceries	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Other:	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times? _______________
When was the last episode? ____________________ If any injury, how did it happen?__________________________________
____ (use back of sheet if needed)
Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: ______________________________,
and who provided it: _________________________ **How long ago?** _______What were the results? ☐ Favorable ☐Unfavorable
Please explain ____

PAST HISTORY – Complaint or Wellness

Please identify any and all types of jobs you have had in the past that have imposed any emotional, chemical, or physical stress on you or your body: ____

____

____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have and **N** for *Never have had***:**

___ Broken Bone ___ Dislocations ___Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

PLEASE MARK P FOR IN THE PAST, C FOR CURRENTLY HAVE AND N FOR NEVER

___ Headache
___ Neck Pain
___ Jaw Pain, TMJ
___ Shoulder Pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Hip Pain
___ Back Curvature
___ Scoliosis
___ Numb/Tingling arms, hands, fingers
___ Numb/Tingling legs, feet, toes

___ Pregnant (Now)
___ Frequent Colds/Flu
___ Convulsions/Epilepsy
___ Tremors
___ Chest Pain
___ Pain w/Cough/Sneeze
___ Foot or Knee Problems
___ Sinus/Drainage Problem
___ Swollen/Painful Joints
___ Skin Problems

___ Dizziness
___ Loss of Balance
___ Fainting
___ Double Vision
___ Blurred Vision
___ Ringing in Ears
___ Hearing Loss
___ Depression
___ Irritable
___ Mood Changes
___ ADD/ADH
___ Allergies

___ Prostate Problems
___ Impotence/Sexual Dysfun.
___ Digestive Problems
___ Colon Trouble
___ Diarrhea/Constipation
___ Menopausal Problems
___ Menstrual Problem
___ PMS
___ Bed Wetting
___ Learning Disabilty
___ Eating Disorder
___ Trouble Sleeping

___ Ulcers
___ Heartburn
___ Heart Problem
___ High Blood Pressure
___ Low Blood Pressure
___ Asthma
___ Difficulty Breathing
___ Lung Problems
___ Kidney Trouble
___ Gall Bladder Trouble
___ Liver Trouble
___ Hepatitis (A,B,C)

SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Occasionally ☐ Never ☐ Former
If you are a former smoker what was the date you started:________________ Date Quit:________________________

2. Alcoholic Beverage: How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Does this condition affect or interfere with your:
☐ Work ☐ Leisure ☐ Sleep ☐ Sports/Exercise ☐ Hobbies ☐ Mental Attitude ☐ Other ______________________
How so ____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister's ☐ brother's ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of. ☐ No ☐ Yes: ___________________________

LIST ALL PRESCRIPTION DRUGS, NON- PRESCRIPTION DRUGS AND ALL SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

LIST ALL MEDICATION ALLERGIES if none, please circle No

Medication Name	Reaction	Onset Date	Additional Comments

QUADRUPLE VISUAL ANALOGUE SCALE **HR#______________**

Patient Name ____ Date ________________________

Please read carefully:
Instructions: Please circle the number that best describes the question being asked.
Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain ____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain ____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain ____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

No pain ____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

No pain ____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

____

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

I hereby authorize payment to be made directly to **Family First Wellness Center** for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **Family First Wellness Center** for any and all services I receive at this office.

____	_______ / _______ / _______
Patient or Authorized Person's Signature	**Date Completed**
____	_______ / _______ / _______
Doctor's Signature	**Date Form Reviewed**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: Chiropractic care seeks to restore health through natural means without the use of medicine, surgery or other invasive means. Chiropractic care is not a substitute for traditional medical care, nor is traditional medical care a substitute for chiropractic. The doctor will use his/her hands or a mechanical device in order to move your joints. Various ancillary procedures, such as Low Intensity Laser Therapy, therapeutic exercise, mechanical massage, hot or cold packs, electric muscle stimulation, therapeutic ultrasound or hydrotherapy may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Rare complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, stroke or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I also have read and agree to the Consent for Use and Disclosure of Protected Health Information on File at Family First Wellness Center .

______________________	______________________	______________
Printed Name	**Signature**	**Date**

RECORD REQUEST AND FINANCIAL RESPONSIBILTY AGREEMENT

Patient name: ________________________________ **SSN**: _________________________ **DOB:** _________________

Billing address:____ **Phone**: ________________________

This is to certify that the above named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, or other health care provider.

This also authorizes this facility to release records, upon receipt of the above named patient's signature, or on an emergency basis, to, but not inclusive of, any insurance carrier, any attorney, health care provider, hospital or immediate family member.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

A photocopy of this agreement shall be considered as effective and valid as the original.

Privacy: The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. You can be assured that this facility takes your privacy seriously and is in compliance with all HIPAA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

____________________________________	______________________________________	_________________
Print Name	**Policyholder/Guarantor's signature**	**Date**