Focus Forward Chiropractic

Health Profile

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you!

Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____ Age: _____ [ ] M [ ] F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Occupation: _____ Name of Employer: _____

SINGLE/MARRIED/DIVORCED/WIDOWED Spouse's Name: _____

Number of Children: _____ Names, Ages & Gender: _____

Do you independently make your own financial decisions for your Health Care? ___YES ___NO

Do you have insurance? ____YES ____NO Name of Insurance Company: _____

Who may we thank for referring you? _____

Health Concerns?	Rate of Severity 1=Mild; 10=Unbearable	When did it Begin?	How Did It Happen?	Did the Problem Begin with an Injury?	Are Symptoms Constant, or On and Off?

What health goals would you like to accomplish through chiropractic care?

_____

_____

If you are experiencing pain, is it: ___ SHARP ___DULL ___NUMBNESS ___BURNING __TINGLING__OTHER

Does the pain travel or radiate anywhere? ____YES ____NO

If YES, please describe: _____

_____

Since your problem started, is it: _____THE SAME ____GETTING BETTER ____GETTING WORSE

What makes it worse? _____

What makes it better? _____

Which other doctors have you seen for this condition? ____CHIROPRACTOR ____MEDICAL DOCTOR _____OTHER

List surgical operations and years: _____

_____

List all medications you are on: _____

_____

When was your last auto accident? _____

Have you had previous chiropractic care? ____YES ____NO

If YES, list most recent date and doctor's name _____

Have you ever been unconscious? ___YES ___NO Have you ever fractured a bone? ___YES ___NO

If YES to either, please describe: _____

_____

Have you had any other bodily trauma? _____

PLEASE CIRCLE ANY CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

Heart Disease Cancer Stroke Spinal Surgery Seizures Spinal Bone Fracture Scoliosis Diabetes

PLEASE CHECK ANY AND ALL ISSUES YOU HAVE HAD WITHIN THE LAST TWO YEARS:

[ ] Asthma	[ ] Arthritis	[ ] Loss of balance	[ ] Chronic Fatigue
[ ] Epilepsy	[ ] Gastric Reflux	[ ] Heart Disorders	[ ] Loss of memory
[ ] Ulcers	[ ] Sciatica	[ ] Nausea	[ ] Loss of smell
[ ] Dizziness	[ ] Numbness in Arms	[ ] Disc Problems	[ ] Loss of taste
[ ] Kidney Problems	[ ] Numbness in Legs	[ ] Liver Disease	[ ] Menstrual Disorders
[ ] Headaches	[ ] Numbness in Hands	[ ] Low Back Pain	[ ] Migraines
[ ] Vertigo	[ ] Numbness in Feet	[ ] Ears ringing	[ ] Neck Pain
[ ] Chest Pain	[ ] Ear Infections	[ ] Sinus Trouble	[ ] Depression
[ ] Sleeping problems	[ ] Digestive disorders	[ ] Irritability	[ ] Anxiety
[ ] Nervousness	[ ] Tension	[ ] Fainting	[ ] Chronic Sinus

Other: _____

LIST SYMPTOMS/COMPLAINTS IN ORDER OF MOST DISCOMFORT:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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Family Health Profile

This form is to assist the doctors of Focus Forward Chiropractic by providing past family history information for their review.

Condition	Spouse	Son	Daughter	Mother	Father
Arm Pain					
Arthritis					
Asthma					
ADD/ADHD					
Allergies					
Back Trouble					
Bed Wetting					
Cancer					
Carpal Tunnel					
Deceased					
Diabetes					
Digestive Problems					
Disc Problems					
Ear Infections					
Fibromyalgia					
Headaches					
Heartburn					
High Blood Pressure					
Hip Pain					
Leg Pain					
Menstrual Disorder					
Migraines					
Neck Pain					
Scoliosis					
Shoulder Pain					
Sinus Trouble					
TMJD					

I clearly understand and agree that all services rendered me are charged directly to me and payment is due when service is rendered and that I am personally responsible for payment.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself and that this chiropractic office does not accept insurance assignment. Furthermore, I understand that this chiropractic office does not prepare and file insurance claim forms with the insurance carrier. I also understand that this chiropractic office will provide me with itemized statements for services rendered that I may use to submit independently with my insurance carrier for determination of benefits payable.

Patient's Signature: _____ Guardian's Signature: _____

Doctor's Signature: _____ Date: _____

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QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name:_____ Date: _____

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

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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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INFORMED CONSENT

- I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.
- I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.
- I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (printed): _____

Patient (or guardian) Signature:_____ Date_____

Witness Signature: _____ Date_____

Doctor's Name (printed): Bethany Raudenbush, D.C.

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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the "*Notice of Privacy Practices*" and that I have read them or declined the opportunity to read them and understand the "*Notice of Privacy Practices*". I understand that this form will be placed in my patient chart and maintained for six years.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

Name	Relationship

AUTHORIZED COMMUNICATIONS PROCEDURES

☐ I understand that e-mail communications are sent via unencrypted methods. I hereby request _ **Bethany Raudenbush, D.C**. _ to communicate with me via e-mail at the following e-mail address: _____ or send postcards and other correspondence via USPS to the address listed in my chart unless otherwise specified here:

☐ I hereby request that _**Bethany Raudenbush, D.C.**_ place all telephone calls or texts to me at the following number/numbers: _____.

☐ I hereby request that **Bethany Raudenbush, D.C.**__ leave no voice mail messages on the above listed or any other telephone listings relating to me.

_____ _____
Patient Name (please print) Parent, Guardian or Patient's legal representative

_____ _____ _____
Patient Date of Birth Signature of Patient or Guardian Today's Date

For Use by Privacy Officer Only

Practice: ____ Accepts _____ Denies Date: _____

Signature of Privacy Officer: _____

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