

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:

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

Other: _____

LIST SYMPTOMS/COMPLAINTS IN ORDER OF MOST DISCOMFORT:

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

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: _____

Focus Forward Chiropractic
900 N. Swallowtail Dr., STE 104D
Port Orange, FL 32129

QUADRUPLE VISUAL ANALOGUE SCALE

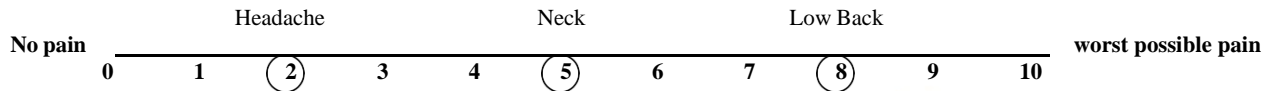
Patient Name: _____

Date: _____

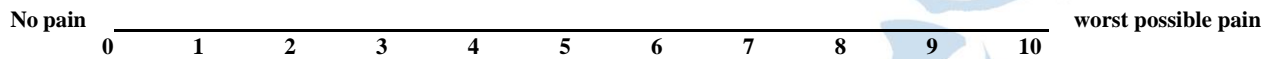
Instructions: Please circle the number that best describes the question being asked.

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.

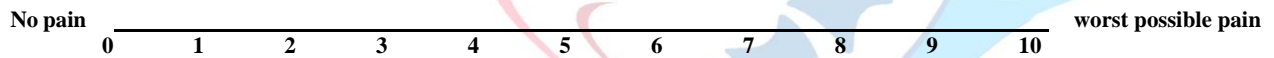
Example:



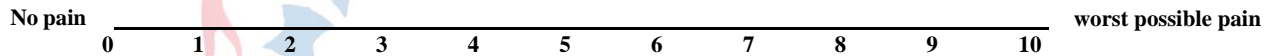
1 – What is your pain RIGHT NOW?



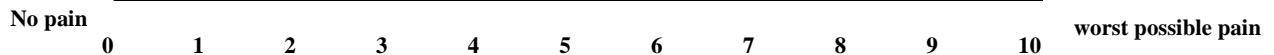
2 – What is your TYPICAL or AVERAGE pain?



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



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



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.

**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: _____