Personal and Family Health History

Name _____
Date _____
Address _____
City _____ State ____ Zip _____
Phone: (H) _____ (W) _____
E-mail _____
Date of Birth _____ (Age _____)

Referred By _____
Social Security # _____
Occupation _____
Employer _____
Marital Status S M D W
Spouse's Name _____
Spouse's Occupation _____

Number of Children and Ages

Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____

Previous Chiropractic Care?

Age _____ Yes___ No___ Reason _____
Age _____ Yes___ No___ Reason _____
Age _____ Yes___ No___ Reason _____
Age _____ Yes___ No___ Reason _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that Apply	***Patient***	***Spouse***	***Child#1***	***Child#2***	***Child #3***	***Chiropractor's Comments***
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____

Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture: side–stomach–back	_____	_____	_____	_____	_____	_____

Current Health Condition

Present Complaint (be brief) Reason For Your Visit Today
Major _____
Pain or Problem started on_____
Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Is this condition getting progressively worse? _____
Other Doctors seen for this condition _____
Any home remedies? _____

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Stomach Upset
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Constipation
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in Ear
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Fatigue	❒ Loss of Taste	
❒ Dizziness	❒ Depression	❒ Diarrhea	

Have you been under drug and medical care? _____
What medications are you taking? _____
How Long? _____ Have you had surgery? _____ What? _____ When?_____
What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to

Please check all that apply

❒ Feel better quickly
❒ Have a healthier spine
❒ Have a healthier body by keeping my nerve system healthy
❒ Live a healthier lifestyle

_____ _____
Signature Date

Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI) To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

Patient/ Guardian initials

_____ 1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

_____ 2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

_____ 3. The Practice's "Notice of Privacy Practices" is also provided at the front desk and in the lending library. I may also request a copy from this office at any time via US Mail.

_____ 4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ 5. I consent to having Superczynski Family Chiropractic, Ltd (SFC) contact me via mail and telephone at my home and office and leaving a message on a machine or with the person answering.

_____ 6. Special circumstances apply to this office, namely open-area adjusting and rehab. Private sessions available upon request.

_____ 7. I authorize the use of my name (first name only) and likeness to be used for office print and internet advertising, brochures, patient testimonials, Chiro Kids wall, and a referral board.

_____ 8. I authorize my name to be written on a daily sign-in log kept at the front desk.

_____ 9. I understand this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent.

_____ 10. I understand that if I do not sign this Consent or revoke consent at any time, the practice has the right to refuse to treat me.

_____ 11. I understand that SFC does not diagnose or treat disease. Rather, they locate and correct spinal subluxations.

_____ 12. I understand and consent to other types of correspondence, including a special occasion card, periodic newsletters and/or general mailings.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship

_____ _____
Witness Date Signed

Reviewed and updated last on 7/12/2010
By Steve Superczynski

What you need to know about what to expect in our office

1 The power that created your body will heal your body.

2 You are the healer – we create the environment and remove the barriers to let your energy to flow.

3 Every time you are adjusted your body functions better – from micro to macro levels. Your body decides what to heal first.

4 We at Superczynski Family Chiropractic, Ltd do not chase symptoms or have an attachment to the outcome of symptoms.

5 We believe that everyone, young and old, needs chiropractic on a regular basis for their lifetime. That said, we will not judge you on your wellness path. Set your priorities by what you think is the healthiest for you. We ask that you are honest with us ***and*** with yourself.

Financial Policy

I understand that having insurance is a contract between my insurance carrier and myself. I authorize my insurance company to pay Superczynski Family Chiropractic, Ltd directly for any bills incurred during my treatment. I also understand that I am responsible for any balance that my insurance does not cover.

In the event Superczynski Family Chiropractic, Ltd (SFC) hires a collection agency or attorney to collect any sums owed by the Customer under this agreement or to otherwise enforce its rights hereunder, Customer agrees to pay the reasonable fees of such agency or attorney and any other reasonable costs and expenses incurred by SFC in enforcing its rights under this agreement, including court costs and filing fees. Any sum not paid by Customer when due and owing is subject to interest at a rate equal to the lesser of 1 and ½ percent per month or the maximum rate allowed by law. Any sum not paid by Customer within 30 days of statement date will be subject to late charges in addition to interest.

Name(Printed) _____ Date _____

Signature _____