# Full Circle Chiropractic & Wellness Center L.L.C.
# Confidential Patient Information

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE FRONT DESK.

## PATIENT INFORMATION:

Today's Date: _____

Name: _____ Date of Birth: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Age: _____ Race: _____ __ Male __ Female

Ethnicity: __Hispanic or Latino __Not Hispanic nor Latino Preferred Language: _____

Marital Status: __ Married __Single __Divorced __Separated __Other_____

E-mail Address: _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation_____ Your Employer: _____

Referred to this Office by: __ Friend/Family Member - Name? _____

__ Google __ Yellow Pages __ Mail __ Clinic Location __ Other_____

Payment for Services will be by: __Cash __Check __Credit Card __Health Insurance __Other

Name of Insurance Co.: _____ Insured's Name: _____

Insured's Date of Birth: _____ Relationship to Insured: _____

Are you covered by more than one insurance company? __Yes __No Name _____

## MEDICAL/FAMILY HISTORY: S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

| S | M | F | | S | M | F | | S | M | F | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| __ | __ | __ | AIDS | __ | __ | __ | dislocated joints | __ | __ | __ | neck pain |
| __ | __ | __ | Anemia | __ | __ | __ | epilepsy | __ | __ | __ | nervousness |
| __ | __ | __ | Arthritis | __ | __ | __ | German measles | __ | __ | __ | numbness |
| __ | __ | __ | Asthma | __ | __ | __ | headaches | __ | __ | __ | polio |
| __ | __ | __ | Back pain | __ | __ | __ | heart trouble | __ | __ | __ | poor circulation |
| __ | __ | __ | Bladder trouble | __ | __ | __ | reproductive disorder | __ | __ | __ | hepatitis |

__ __ __ Bone fracture
__ __ __ Cancer
__ __ __ Chest pain
__ __ __ Concussion
__ __ __ Convulsions
__ __ __ Diabetes
__ __ __ Indigestion
__ __ __ high blood pressure
__ __ __ HIV/ARC
__ __ __ kidney disorder
__ __ __ bowel control loss
__ __ __ menstrual cramps
__ __ __ multiple sclerosis
__ __ __ muscular dystrophy
__ __ __ rheumatic fever
__ __ __ rheumatism
__ __ __ scarlet fever
__ __ __ serious injury
__ __ __ sinus trouble
__ __ __ tuberculosis
__ __ __ venereal disease

Have you been treated by a physician for any health condition in the last year? __Yes __No

Describe Condition: _____ Date of Last Physical Exam: _____

SURGICAL HISTORY: 1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Have you ever had a metal implant? __Yes __No gunshot injuries? __Yes __No

ACCIDENT HISTORY:__Job __Auto __Other 1. _____ Date: _____

__Job __Auto __Other 2. _____ Date: _____

__Job __Auto __Other 3. _____ Date: _____

## SOCIAL HISTORY:

Do you drink alcoholic beverages? __Yes __No if so, how much per week? _____

Do you use any tobacco products/smoke? __Yes __No If so, packs per day: _____

Do you take vitamin supplements? __Yes __No If so, please list: _____

Do you consume caffeine? __Yes __No If so, how much per day? _____

Do you exercise? __Yes __No If so, what is the frequency and type of exercise? _____

What are your hobbies: _____

## PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms 1-10 (1 being least serious)

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

SYMPTOMS ARE WORSE IN __MORNING __AFTERNOON __NIGHT

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: __JOB RELATED INJURY __AUTO ACCIDENT __OTHER __ACCIDENT

__ILLNESS __UNKNOWN CAUSE __GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR (S) ____DAY (S) __WEEK (S) ___MONTH (S) ___YEAR (S)

SYMPTOMS/COMPLAINTS: __COME & GO __ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: __NO __YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS? _____

_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION (S): _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS: __NO __YES WHAT KIND? _____

_____

ARE YOU TAKING ANY MEDICATIONS: __NO __YES WHAT KIND? _____

_____

ARE YOU PREGNANT:__NO __YES DATE OF LAST MENSTRUAL PERIOD_____

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**
__BENDING __REACHING __STRAINING AT STOOL __COUGHING __SITTING __TURNING HEAD
__LIFTING __SNEEZING __WALKING __LYING DOWN __STANDING

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**
__BENDING __SITTING __LIFTING __STANDING __LYING DOWN __TURNING HEAD __REACHING __WALKING

**PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:**
__Blurred vision __buzzing in ears __cold feet __cold hands __cold sweats __concentration loss /confusion __constipation __depression /weeping spells __diarrhea __dizziness __face flushed __fainting __fatigue __fever __Head seems too heavy __headaches __insomnia __light bothers eyes __loss of balance __loss of smell __loss of taste __low resistance to colds __muscle jerking __numbness in fingers __numbness in toes __pins and needles in arms __pins and needles in legs __ringing in ears __shortness of breath __stiff neck __stomach upset

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or Chiropractic office. I authorize the doctor to release all information necessary to communicate with personal Physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am Responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be Immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____