FAMILY ROOTS CHIROPRACTIC ADULT

Today's Date_______________

Patient Information

Name ____ Age ______

Date of Birth ______________________________

Gender ❑ M ❑ F

Height _____________________ Weight ____________________________

Street Address ________________________________ City __________________ State ______ Zip ______________

Email: ______________________________________ Primary Phone: ______________________________________

Emergency Contact ____________________________ Relationship: _____________________ Phone ____________

How did you hear about us? ____

Who is your primary care physician? ____

Date and reason for your last doctor's visit: ____

Occupation: __________________________ Employer: ____

Do you have children? _________ If so, what are their names and ages? ____________________________________

____

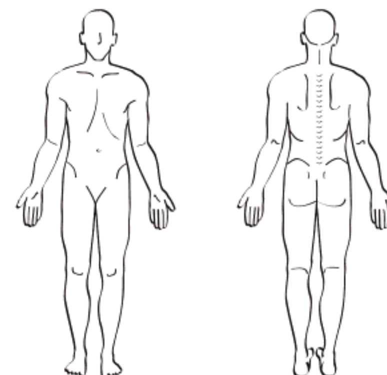
Are you also receiving care from any other health professionals? ____

- If yes, please name them and their specialty: ____

Please note any significant family medical history: ________________________________

Current Health Conditions

Please indicate where you are experiencing pain or discomfort.
X = Current condition 0 = Past condition



What health concern(s) bring you into our office? ________________________________

Have you received care for this before? ❑ Yes ❑ No

- If yes, please explain: ____

When did the condition(s) first begin? ____

How did the problem start? ❑ Suddenly ❑ Gradually ❑ Post-Injury

Is this condition: ❑ Getting Worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Unsure

What makes the problem better? ____

What makes the problem worse? ____

Can you describe the discomfort? ❑ achy ❑ dull ❑ sharp ❑ shooting ❑ throbbing

❑ other: ____

Rate your condition on a scale of 0-10 (0 - no discomfort 10 worst discomfort ever) ______

Your Health Goals

Your top three health goals you want to achieve within our office:

1.____

2.____

3.____

Chiropractic History

What would you like to gain from chiropractic care? ❑ Resolving existing condition(s) ❑ Overall wellness ❑ Both

Have you ever visited a chiropractor? ❑ Yes ❑ No If yes, what was the name: ______________________________

What is their specialty? ❑ Pain Relief ❑ Physical Therapy & Rehab ❑ Nutritional ❑ Subluxation based ❑ Other: ______

Do you have any health concerns for other family members today? ______________________________________

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries, or other injuries as an adult? ❑ Yes ❑ No

If yes, please explain: ____

Notable childhood injuries? ❑ Yes ❑ No If yes, please explain: ____________________________________

Youth or college sports? ❑ Yes ❑ No If yes, list major injuries: ___________________________________

Any auto accidents? ❑ Yes ❑ No If yes, please explain: ____

Exercise frequently? ❑ None ❑ 1-2x/week ❑ 3-6x/week ❑ Daily

If yes, what type of exercise? ____

How do you normally sleep? ❑ Back ❑ Side ❑ Stomach Do you wake up: ❑ Refreshed and ready ❑ Stiff and tired Do you commute to work? ❑ Yes ❑No If yes, how many minutes per day? _______________________________

List any problems with flexibility. (Ex. putting on shoes/socks, etc.) ______________________________________

How many hours per day do you typically spend sitting at a desk or on a computer, tablet, or phone? ______________

TOXINS: Chemical and Environmental Exposure

Please rate your CONSUMPTION for each:

	None		Moderate		High
Alcohol	1	2	3	4	5
Water	1	2	3	4	5
Sugar & Sweets	1	2	3	4	5
Dairy	1	2	3	4	5
Gluten	1	2	3	4	5

	None		Moderate		High
Processed Foods	1	2	3	4	5
Artificial Sweeteners	1	2	3	4	5
Sugary Drinks	1	2	3	4	5
Cigarettes	1	2	3	4	5
Recreational Drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs/other you are taking, and why.

____

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		Moderate		High
Home	1	2	3	4	5
Work	1	2	3	4	5
Life	1	2	3	4	5

	None		Moderate		High
Money	1	2	3	4	5
Health	1	2	3	4	5
Family	1	2	3	4	5

Please list any other mental and/or emotional stresses.

____

Acknowledment & Concent

PLEASE READ AND SIGN

1. I have been informed that a copy of Family Roots Chiropractic's "Notice of Privacy Practices for Protected Health Information *(HIPAA)"* brochure is available for my review.

2. I consent to receive communication from Family Roots Chiropractic via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.

3. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to Family Roots Chiropractic. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.

4. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

5. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Ashley Rath permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature ____ Date: ____________________

Thank you for choosing Family Roots Chiropractic.

We look forward to helping you.