FAMILY FIRST CHIROPRACTIC
and Wellness Center

Patient Introduction

Personal History:

Your Name: _____ (_____)
First Middle Last Nickname

Gender: _____ Pronoun:_____

Address: _____

City: _____State: _____ Zip:_____

Social Security Number _____ - _____ - _____ (This line must be filled out)

Telephone: Home:_____ Bus: _____

Cell:_____ Cell Carrier: _____

Do you want to opt in for text message appointment reminders: Y N

Emergency Contact:_____Phone:_____

Email Address: _____

Birth Date: Month: _____ Day: _____ Year: _____

Marital Status:_____

Children's names and ages: _____

_____

Occupation: _____

Military Service: Y N Current or Veteran Branch _____

Employer: _____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor:_____

Reason for leaving:_____

Present MD: _____ City: _____

Referred to our Office by:_____

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

Signature: _____ Date: _____

FAMILY FIRST CHIROPRACTIC
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Adult Consultation History

Your Name: _____

What are your health objectives or goals: _____

_____

Your Main Complaints: _____

How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

_____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

_____

How much older does this make you feel: _____

Are you healthier today than you were 5 years ago? _____

If so, what did you do to improve your health? _____

_____

Our goal with our new patient procedure is to determine the underlying root cause of your health issue(s). Once we figure out the cause, we will place you on a course of care aimed at correcting the problem.

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us help you be at optimal wellness: _____

Are you on any type of medication? Please list all (please include regularly used over the counter medication.

Medication Name	Dosage and Frequency (i.e. 5mg 1x day)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Do you take any vitamins/supplements?

Product	Dosage and Frequency

Standard Authorization of Use and Disclosure of Protected Health Information

The information covered by this authorization includes Appointments, Account and Billing Information, Personal Health Information, and Care Recommendation. I authorize Family First Chiropractic to give my information to the following people: _____

_____.

Primary Care Doctor:		Ob/Midwife:	
Pediatrician:		Doula:	
Lactation Consultant:		PT or OT:	
CST/Massage:		Dentist:	
Other:		Body Work:	

I acknowledge that I have been informed and given the opportunity to review the Notice of Privacy Practices for Family First Chiropractic and Wellness Center. I also acknowledge that I have been given the option to receive a copy of this Notice.

SIGNATURE: _____ DATE: _____

Date of your last menstrual period: _____

Are using any means of contraception? _____

Estimated Due Date:_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Name_____ Age_____ Date_____

Review of Systems

Heart Attack	No Yes	Emphysema	No Yes	Asthma	No Yes
Heart Failure	No Yes	Coughing up Blood	No Yes	Unplanned Weight Loss.....	No Yes
Heart Disease	No Yes	Tuberculosis	No Yes	Enlarged Lymph Nodes…..	No Yes
Osteoporosis……..	No Yes	Pneumonia	No Yes	Celiac/Crohn's/Colitis….....	No Yes
Multiple Sclerosis……..	No Yes	Severe Heart Burn	No Yes	Anesthesia Problems.....	No Yes
Parkinson's.....	No Yes	Hiatal Hernia	No Yes	Depression and/or Anxiety..	No Yes
High Blood Pressure …...	No Yes	Stomach Ulcers	No Yes	Auto-Immune Disorders.....	No Yes
Poor Circulation.....	No Yes	Hepatitis	No Yes	Eye Disorders.....	No Yes
High Cholesterol.....	No Yes	Jaundice.....	No Yes	Hearing Loss	No Yes
Stroke	No Yes	Kidney Infection	No Yes	Menstrual Problems ……	No Yes
Paralysis	No Yes	Irritable Bowel……	No Yes	Prostate Problems.....	No Yes
Severe Headaches	No Yes	Thyroid Problems.....	No Yes	Pacemaker.....	No Yes
Seizures	No Yes	Diabetes	No Yes	Urinary Problems……..	No Yes
Blackout Spells	No Yes	Arthritis/ Joint Pain	No Yes	Cancer_____	
Head Injury.....	No Yes	Skin Disorders…….	No Yes	Other_____	
Meningitis.....	No Yes	Acid Reflux……..	No Yes	Other_____	

PAST HISTORY

- Please list any other medical problems not listed above.

_____ _____

_____ _____

_____ _____

- **Please list any previous SURGERIES**

Surgery	Date
_____	_____
_____	_____
_____	_____

Are you ALLERGIC to?

Wheat/Gluten?	No Yes
Dairy?	No Yes
Essential Oils?	No Yes
Latex?	No Yes
Lotions?	No Yes
Laundry Detergent?	No Yes
Medicine/Vitamins (list)?	No Yes
Other Things (list)?	No Yes

_____

_____

_____

SOCIAL HISTORY

- Do you SMOKE/use tobacco? No Yes how much/how often?_____
- Do you drink ALCOHOL? No Yes how much/how often?_____
- Do you drink COFFEE/CAFFIENE? No Yes how much/how often?_____
- Do you Exercise? No Yes how much/how often?_____
- Work Activity? Sitting Standing Light Labor Heavy Labor
- Stress Level? Low Moderate High Do you feel you handle stress well? No Yes
- Do you sleep well? No Yes I sleep on: Back Side Stomach How many hours? _____

Family Health History: Please list Major Health Problems and Family Member

_____ _____

_____ _____

_____ _____

Medications/Vitamins	Injuries/Fractures/Car Crashes	Anything else we need to know?
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HEALTH HISTORY

Patient Name: _____ **Date:** _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn's Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Press								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								

Additional Comments:

_____

_____

_____

Thank you!