Chiropractic Family Health Center

Dr Kimberly J Bailey/Dr Isaiah R Stephan

Date:_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____Cell Phone: _____-_____-_____

Email Address: _____ Do you want our monthly newsletter? _____

Occupation:_____Place of employment:_____

Date of Birth: _____Age:_____ Social Security #: _____-_____-_____ Gender: Male - Female

Name of spouse:_____Preferred language: _____Race/Ethinicity:_____

Who is your primary care physician?_____

Who may we thank for referring you to our office?_____Relationship:_____

Name of health insurance: _____Who is primary holder:_____Through where:_____

Did you check your chiropractic coverage?_____What do you believe your coverage is? _____

List any Allergies:

☐ Amoxil ☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Codeine ☐ Dairy ☐ Dust ☐ Eggs ☐ Environmental

☐ Latex ☐ Molds ☐ Nickel ☐ NONE ☐ Peanut/Tree Nuts ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Sulfa ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

Check any Surgeries that you have had:

☐ Appendix ☐ Back ☐ Brain ☐ Carpal Tunnel ☐Cervical Disk ☐ Chest ☐ Disc ☐ EENT ☐ Elbow ☐ Foot

☐ Gallbladder☐ Gastrointestinal ☐Gynecological☐ Heart☐ Hernia ☐ Hip ☐ Knee ☐ Lumbar Disc☐ Neck

☐ Neurological ☐ Obstetrical☐ Podiatric☐ Shoulder ☐ Thoracic Disc ☐ Wrist ☐ Other: _____

List ALL PAST Medical History conditions:

☐ Acid Reflux ☐ Anxiety ☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones

☐ Cancer ☐ Carpal Tunnel ☐ Chest Pain ☐ Constipation ☐ COPD ☐ Crohn's Disease ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Ear Infections ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting

☐ Fatigue ☐ Fibromyalgia ☐ Foot Pain ☐ Genetic Spinal Condition ☐ GERD ☐ Gout ☐ Hand Pain

☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure ☐ High Cholesterol ☐ Hip Pain ☐ HIV

☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain☐ Low back pain ☐ Lupus ☐ Menstrual Problems

☐ Mid-Back Pain ☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems

☐ Osteopenia ☐ Osteoporosis ☐ Pacemaker ☐ Parkinson's ☐ Polio ☐ Prostate☐ Rib Pain ☐ Scoliosis

☐ Shoulder Pain ☐ Significant Weight Change ☐ Sleep Apnea ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: _____

What is your major complaint?

*******(please list** only one** on this page and do your next complaint on the next page):**

Circle: neck -mid back -Low back —— other: _____

Side: ☐ left ☐ right ☐ center ☐ both **Date problem began:** _____

How did this problem begin (falling, lifting, etc.)? _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) :

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Intensity: ☐mild ☐moderate ☐severe ☐unbearable ☐none

Describe the nature of your symptoms:

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Tightness

☐ Stabbing ☐ Throbbing ☐ Radiating Pain-radiates to _____

What makes your pain better?

☐Acupuncture☐Chiropractic☐Heat☐Ice☐Massage☑Nothing☐PainMeds☐Sleep/rest☐Stretching

What are your expectations?:

☐Become pain free ☐Explanation of my condition ☐Learn how to care for condition on my own ☐Reduce sympto

☐Resume normal activity

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What activities aggravate your condition:

- o Bathing
- o Bending
- o Bending Arm
- o Bending Leg
- o Care of others/Pets
- o Caring for Children
- o Carrying Objects
- o Climbing Stairs
- o Concentrating
- o Cooking/Cleaning
- o Crouching/Squatting
- o Doing Hobbies
- o Dressing
- o Driving
- o Exercise/Sports
- o Gardening
- o General Mobility
- o Holding onto objects
- o Keeping balance
- o Knitting
- o Leaning
- o Lifting
- o Lying down
- o Moving Joint/s
- o Mowing
- o Personal hygiene/Grooming
- o Reaching out/up/down
- o Seeing
- o Sewing
- o Sexual Activity
- o Shopping
- o Sitting
- o Sleeping
- o Standing
- o Turning
- o Twisting
- o Using the phone
- o Walking
- o Working
- o Yard work

This form was reviewed by: _____

What is your 2nd complaint? _____

Circle: neck -mid back -Low back —— other: _____

Side: ☐ left ☐ right ☐ center ☐ both **Date problem began:** _____

How did this problem begin (falling, lifting, etc.)? _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) :

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This form was reviewed by: _____

Have you ever had chiropractic care at another office?_____When?_____ Where?_____

If so, did you have xrays?_____When was your last adjustment?_____

Date of last x-ray:_____

****Please list your Medications/supplements and what they are for (OR GIVE US A LIST ON A SEPARATE PIECE OF PAPER):**

_____

_____

_____

Please list MEDICATIONS that you are allergic to:_____

List your **Family History:**

Example: Maternal Grandmother – High blood pressure or Paternal Grandfather – Heart disease etc

_____

_____

_____

_____

Do you smoke? ☐ No ☐Yes

Do you drink alcohol? ☐ No ☐Yes - how many per day? _____

Do you drink caffeine? ☐ No ☐Yes - how many per day? _____

Do you exercise? ☐ No ☐Yes (what forms and how often):

_____

What is your favorite sleeping position? _____

Are you now pregnant?____Are you wearing any form or arch supports or orthotics?_____

What kind of mattress do you now sleep on? _____How old is your mattress? _____

In case of emergency or someone who may know how to reach you in case we cannot find you to reschedule, please call:

_____

Name – relationship-telephone number

_____

Name – relationship-telephone number

INFORMED CONSENT

Chiropractic doctors who perform manipulation are required by law to obtain your informed consent before starting treatment.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I understand that in very isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Strokes from chiropractic adjustments are very rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning.

Tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Reasonable alternatives to these procedures have been explained to me. I understand that neglecting care may have potential risks that may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology, as well as a lowered immune system leading to disease.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and freely.

Chiropractic Family Health Center
Dr. Kimberly J. Bailey/Dr. Isaiah R. Stephan
PO Box 8120 138 Halifax Street
Winslow, Maine 04901

Patient's Written Acknowledgement of Doctor's Notice of Privacy Practices

I, _____, acknowledge that I have been given the opportunity to read the *Chiropractic Family Health Center's,* Notice of Privacy Practices located in the reception area.

Signature:_____ Date:_____

Consent to Care

I,_____, permit Dr. Kimberly J Bailey and whomever she designates as her associate to administer chiropractic care as she deems necessary. Chiropractic benefits may be covered by my insurance, but I know that I am personally responsible for payment of services rendered. I have received information about risks and benefits involved in the evaluation of my condition and recommended treatments.

Signature:_____ Date:_____

CONSENT TO X-RAY (PARENT AUTHORIZING XRAYS ON A MINOR CHILD)

I, _____authorize Dr. Kimberly Bailey or her associate to take any x-rays necessary for diagnosis and treatment of _____(minor's name).

Signature:_____ Date:_____

PAYMENT AND/OR ASSIGNMENT OF BENEFITS

I UNDERSTAND I AM RESPONSIBLE FOR PAYING ALL COSTS ASSOCIATED WITH MY EVALUATION AND CARE. If I have health insurance, I understand I am financially responsible in the event all or some payment is denied by my insurance carrier. **I am also responsible for those charges not covered by my insurance as deductible, co-pays and any other treatment that are not included as an insurance benefit.**

I authorize my health insurance carrier(s) or third parties that are responsible for paying for my health care to pay costs associated with my evaluation and care directly to the Chiropractic Family Health Center. **This is a direct assignment of my rights and benefits under this policy.** A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the Chiropractic Family Health Center to appeal any unfavorable payment decisions on my behalf. I further authorize the release of any information pertinent to the appeal to the insurance company involved in this case. I authorize the Chiropractic Family Health Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature:_____ **Date:**_____

Chiropractic Family Health Center

Halifax Street, P.O. Box 8120
Winslow, Maine 04901
Telephone: (207) 873-5161

Name_____ Date_____ Acct#_____

Physical Activity Readiness Questionnaire (PAR-Q)

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
   Yes ☐ No ☐ If yes, please explain: _____
   _____
2. Do you feel pain in your chest when you do physical activity?
   Yes ☐ No ☐ If yes, please explain: _____
   _____
3. In the past month, have you had chest pain when you were not doing physical activity?
   Yes ☐ No ☐ If yes, please explain: _____
   _____
4. Do you lose your balance because of dizziness or do you ever lose consciousness?
   Yes ☐ No ☐ If yes, please explain: _____
   _____
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
   Yes ☐ No ☐ If yes, please explain: _____
   _____
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
   Yes ☐ No ☐ If yes, please explain: _____
   _____
7. Do you know of any other reason why you should not do physical activity?
   Yes ☐ No ☐ If yes, please explain: _____
   _____

This form has been reviewed by: _____