Confidential Patient Case History

Farkas Chiropractic Clinic

Your Health & Wellness Center

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Name_____Date:_____Social Security#_____

Address_____City_____State_____Zip_____

Phone_____ (Circle One) Home Work Cell Alt Phone_____

Email: _____ Birthdate: _____# of Children _____

Marital Status M S W D Occupation_____Employer:_____

Emergency Contact Name & Phone:_____

Primary Care Doctor's Full Name and Phone Number:_____

How Were You Referred To Our Clinic?

Most People are referred to our office by a family member or friend. What made you decide to visit our office?

_____

❑ Friend/Family Member Name_____

Other Personal Referral: ❑ Attorney ❑ Physician ❑ Health Fair, Location and Date:_____

❑ Insurance Co., Name of Insurance Co._____

Other: ❑ Office Sign/Location ❑ Our Website ❑ Internet Search ❑ Gift Certificate

❑ Source Not Named:_____

Health Information : Have you had previous chiropractic care? _____

What is your major complaint?_____

_____

Other complaints:_____

How long have you had this condition? _____Have you had this or similar conditions in the past?_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine Other_____

How long has it been since you really felt good?_____

Other doctors who treated this condition:_____

_____

List surgical operations and years: _____

_____

_____

_____

Drugs you now take: ❑ Nerve pills ❑ Pain Killers ❑ Muscle Relaxers ❑ "Pep" Pills ❑ Tranquilizers ❑ Insulin ❑ Birth Control Pills ❑ Others _____

Age of Mattress____ ❑ Comfortable ❑ Uncomfortable

Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Support

Have you been in an auto accident? ❑ Past Year ❑ Past 5 Years ❑ Over 5 Years ❑ Never ❑ None

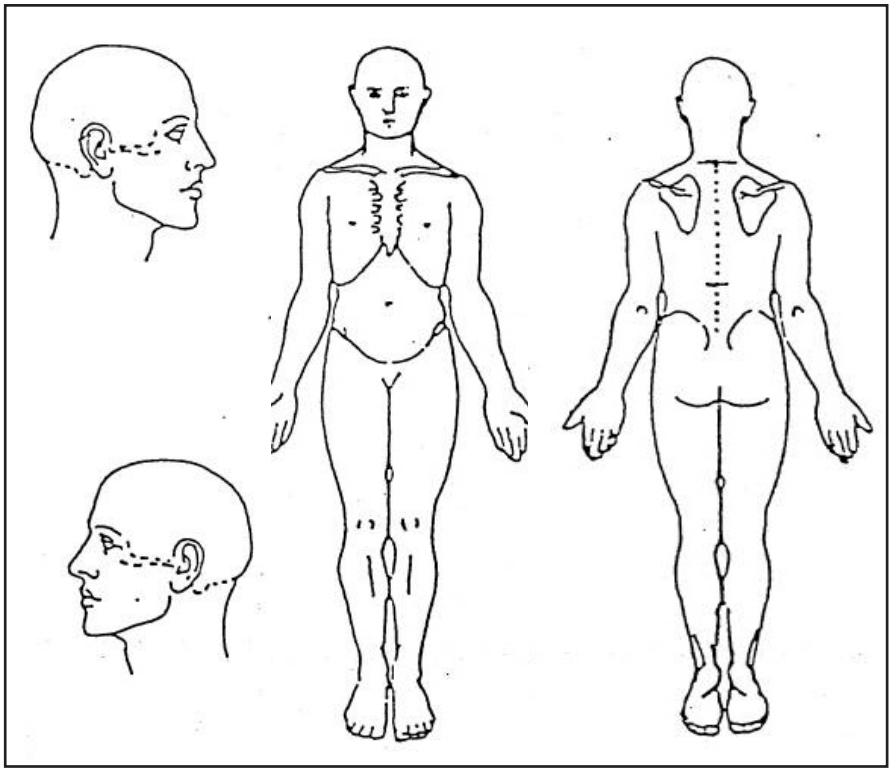
Describe_____

_____

Have you had any other personal injuries or accidents? ❑ Past year ❑ Past 5 Years ❑ Over 5 years ❑ None

Describe: _____

Please mark your areas of pain on the figures below.



Have you ever suffered from:

Allergies _____
Arthritis _____
Asthma _____
Backaches _____
Constipation _____
Diabetes _____
Digestive Disorders_____
Dizziness _____
Excessive Bleeding _____
Headaches _____
Heart Trouble _____
Neck Pain _____
Nervousness _____
Sciatica _____
Sinus Trouble _____
Sleep Problems _____

Family Health Information (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

Name	Relation	Past and Present Health Problems

Office Policy:

I understand that fees are payable at the time of service unless other arrangements are made in advance or I am a member of an insurance group that has made prior arrangements for my care with this office (HMO, PPO, etc.) I am responsible for my full co-payment and/or deductible on each visit. I understand and agree that health and accident policies are an agreement between my insurance company and myself. I understand that Farkas Chiropractic Clinic will prepare all necessary reports and forms in order to collect the proper amounts from my insurance carrier. I understand that I am personally responsible for any deductible, co-payments, or non-covered services, or nonpayment by the insurer for any reason. I understand that FCC can only verify and not guarantee benefits from my insurer. Knowing my benefits is my responsibility. I understand that when I terminate care that all fees are immediately due and payable unless other arrangements are made in writing. I authorize this office to furnish requested information to my insurer or attorney.

Consent To Treat A Minor

I authorize Farkas Chiropractic Clinic physicians and whomever they designate as assistants to examine, x-ray and administer appropriate care as they deem necessary to my child_____(name of child).

Signed _____(Parent or Guardian)

Printed Name:_____Date_____

Acknowledgment of Receipt of Notice of Privacy Practices: _____ (Patient Initials)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be places in my patient chart and maintained for 6 years.

REQUIRED: People I authorize the Practice to release Personal Health Information (PHI)

_____

Name Relation Phone Number

Non – Covered Supplies: _____ (Patient Initials)

I understand that if I received electric stimulation therapy in conjunction with my adjustment, I will receive a set of personal re-usable electrode pads. These pads are non-covered by most insurance companies and will be my responsibility. Typically, 1 set of pads will last through the average course of treatment. The cost of the pads is $20.00

Consent to Text or Email for Appointment Reminders and Other Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment and/or provide other general communication/information related Farkas Chiropractic Clinic. By signing below, I consent to receiving appointment reminders and other communications/information at that email or text address listed below.

_____ **(Patient Initials)** I consent to receive text messages from Farkas Chiropractic at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/communication/information unless I request a change in writing.

The cell phone number that I authorize to receive text messages: _____

The email address that I authorize to receive emails (**PLEASE PRINT CLEARLY**):_____

Farkas Chiropractic Clinic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Print Patient Name:_____

Signed _____(Parent or Guardian) Date_____