Ferguson Family
CHIROPRACTIC

PERSONAL HEALTH HISTORY

Date: _____

Name: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Provider: _____

Email: _____

Date of Birth: _____ Guardian Name: _____

Marital Status: S M D W O Spouse's Name: _____ Age: ____

Children's Names/Age: _____

Employer Name: _____ Occupation: _____

How Did You Hear About Us?: _____ Hobbies: _____

Name of Previous Chiropractors: _____

When was your last visit: _____ how long were you receiving chiropractic adjustments: _____

Reason for coming in: _____

INJURIES:

What accidents have you had (ex. bicycle, car, motorcycle, sports, slips/falls) at work or at home?

Include Dates:

_____

_____

Were you ever knocked unconscious? YES NO

What fractures or broken bones have you had? Include dates: _____

_____

SURGERY:

What major surgery have you had? Include dates: _____

_____

What minor surgery have you had? (Tonsillectomy, appendectomy, wart/cyst removal, dental extr.)

_____

4609 South Main Street Acworth, Ga 30101
Phone: 770.966.1800 Fax: 770.966.0413

MEDICATION:

Present Prescription drugs	Past prescription drugs	Over-the counter drugs (aspirin, cold tablets, cough syrup)
_____	_____	_____
_____	_____	_____
_____	_____	_____

THERAPY:

Are you presently under any therapeutic care? _____ What type? _____
What therapeutic care have you been under in the past two years? (radio, chemo, physio, electro, etc.)
Include Dates: _____

BIRTH RECORD:

Type of birth (vaginal, cesarean, forceps, etc.) _____
Complications during your mother's pregnancy or during birth: _____
Complications after your birth: _____

CURRENT HEALTH:

How do you describe your current health: _____
How would you describe your family's health: _____
Describe your: Vision: _____ Hearing: _____ Coordination: _____
Do you use any of the following: TOBACCO ALCOHOL COFFEE/TEA SODA MILK
Level of stress in your life: MILD MODERATE EXTREME Rating of stress: 1 2 3 4 5 6 7 8 9 10
Do you purchase any of the following?
_____Bottled drinking water _____Vitamins _____Health food products (organic products etc.)

FINANCIAL INFORMATION:

Who is responsible for this account? SELF SPOUSE OTHER Name if other: _____
What method of payment will you be using? INSURANCE CASH CHECK CREDIT CARD

Please check any of the following that give you difficulty or you had had recently

___Headaches	___Fainting	___Shortness of breath	___Numb legs/feet
___Shooting head pains	___Loss of balance	___Mid-back pain	___Constipation
___Sinus trouble	___Ringing in ears	___Heart attack	___Kidney trouble
___Loss of smell	___Blurred vision	___Low blood pressure	___Menstrual cramps
___Allergies	___Lights bother eyes	___High blood pressure	___Menstrual irregularity
___Hayfever	___Neck pain	___Anemia	___Diabetes
___Asthma	___Muscle spasms in neck	___Nerves/nervousness	___Painful joints
___Inflammation of throat	___Shldr/arm tightness	___Inner tension	___Swollen joints
___Thyroid trouble	___Shldr/arm pain	___Irritability	___Pins & needles in leg
___Facial twitch	___Pins & needles in arms	___Gall bladder trouble	___Swollen ankles
___Loss of memory	___Pins & needles in hands	___Indigestion	___Cold Feet
___Fatigue	___Cold Hands	___Intestinal gas	___Pain in legs/feet
___Depression	___Numbness in arms/hands	___Low back pain	___Hip pain
___Spinal curvature	___Prostate trouble	___Stroke	___Jaw pain/TMJ
___Chest pain	___Bed wetting	___Arthritis	___Ulcers
___Ear ache	___Cancer	___Seizures	

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TERMS OF ACCEPTANCE

If a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of verve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of Ferguson Family Chiropractic to administer such care that is necessary for my particular case. This may include consultation, examination, adjustments, or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: _____ Date: _____
Signature of parent or guardian if minor

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HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request a copy if you would like one.

This Notice of Privacy Practice also describes my rights and duties of the chiropractor with respect to my Protected Health Information. I hereby give permission to Ferguson Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following.

SPECIFIC AUTHORIZATIONS

- I give permission to FFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If FFC contacts me by phone, I give them the permissions to leave a phone message on my answering machine or voice mail.
- I give permission to FC to use my name on a welcome board, referral board and birthday board.
- I give permission to FFC to use my photograph on the patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on the their website or in ads in print media.
- I give FFC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance you access to quality health care and health information. This authorization will remain in effect for the duration of my care at FFC plus 7 years or until revoked by me.

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RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action to reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of FFC. The written notice must contain the following information:

Your name, Social Security number & date of birth;
A clear statement of you intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. (Minimum necessary standards apply)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or cop, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

DOB: _____
My Name (please print): _____
My Signature: _____
Today's date: _____

Name of personal Representative (if someone is designated to act on your behalf)
Name (please print): _____
Signature of Personal Representative: _____
Description of Representative's Authority to Act on Patients Behalf: _____

LIFE University

P.E.A.K.

PRACTICE EXCELLENCE ART AND KNOWLEDGE

P.E.A.K. Patient Disclosure and Consent

I, the undersigned, have been informed that Doctor _____ is participating in the Life University Clinic PEAK Program, which is a senior chiropractic clinic preceptorship course. *The intern will be identified by displaying a Life University student ID badge while on duty as a PEAK intern.*

I have been informed that a Chiropractic Student Intern may be assigned to perform some part of my clinical care at this office and the intern is NOT yet a licensed Doctor of Chiropractic. I understand that the Intern is working under the authority and auspices of this office.

( ) I agree to allow the Intern to perform assigned clinical services under the supervision of the Extension Faculty Doctor. *I further understand that I may withdraw this permission at any time by notifying the doctor or the intern.*

( ) I DO NOT agree to allow the Intern to perform assigned clinical services under the supervision of the Extension Faculty Doctor.

PRINT NAME _____

Signature _____

Date Signed _____

JM: July 2016