FAIRWOOD
Chiropractic & Physical Therapy

Patient Information

Date _____

Patient_____

Address_____

City_____ State_____ Zip_____

Sex: ❑ M ❑ F Age_____ Birthdate_____

❑Single ❑ Married ❑ Widowed ❑ Separated ❑Divorced

Patient SS# _____

Occupation _____

Employer_____

Employer Address_____

Employer Phone _____

Spouse's Name_____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Contact Information

Home:_____ Cell:_____

Work:_____ Ext._____

Email (office use only)_____

Emergency Contact:
Name:_____Relationship:_____

Phone:_____ Phone2:_____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co._____

Policy # _____

Is patient covered by additional insurance? ❑Yes No❑

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient _____

Insurance Co._____

Policy # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr.Rahman all insurance benefits, if any, other- wise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Date

_____
Relationship to Insured

Accident Information

Is condition due to an accident? ❑ Yes ❑ No

Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑Other

Attorney Name (if applicable)_____

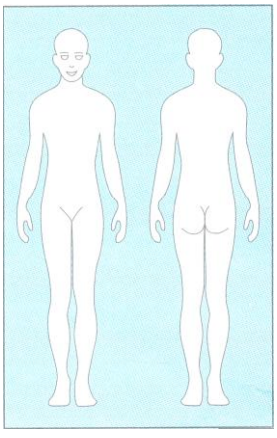
Patient Condition

Health Problem/Reason For Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? ❑ Monthly ❑Bi-Monthly ❑Weekly ❑Daily ❑Other_____

Is it constant or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑Daily Routine ❑ Recreation

Activities or movements that are painful to perform:❑ Sitting ❑Standing ❑ Walking❑ Bending❑ Lying Down

Health History

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy

❑Chiropractic ❑ None ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition?_____

_____

Date of Last: Physical Exam _____ Spinal X-Ray_____ Blood Test _____

Spinal Exam _____ MRI, CT-Scan_____

Primary Care Physician's Name _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Nervousness
- ☐ Numbness
- ☐ Wheezing

MUSCLES & JOINTS
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ Broken Bones
- ☐ Arthritis

CARDIO-VASCULAR
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Poor Circulation
- ☐ Heart Trouble

EAR/NOSE/THROAT
- ☐ Earache
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Nasal Blockage
- ☐ Nose Bleeds
- ☐ Pain Behind Eyes
- ☐ Sinusitis
- ☐ Sore Throats
- ☐ Tonsillitis

GASTRO-INTESTINAL
- ☐ Colon Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Liver/Gallbladder
- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Ulcer

RESPIRATORY
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Difficulty Breathing

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Infection
- ☐ Painful Urination
- ☐ Prostate Problems

SKIN OR ALLERGIES
- ☐ Boils
- ☐ Bruising Easily
- ☐ Dryness
- ☐ Eczema/Rash/Dermatitis
- ☐ Allergy _____
- ☐ **Other_____**

FOR WOMEN ONLY
- ☐ Cramps/Backaches
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Miscarriage
- ☐ Painful Periods
- ☐ Vaginal Discharge
- ☐ Breast Pain

❑ **Pregnant at this time?**

Exercise Habits
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits

☐ Smoking Packs/Day_____

☐ Alcohol Drinks/Week____

☐ Coffee/Caffeine Drinks Cups/Cans/Day___

Stress Levels ☐ High ☐ Normal ☐ Low

Injuries/Surgeries/Fractures	Description	Date/Year

MEDICATIONS

_____

_____

_____

Pharmacy Name:_____

ALLERGIES

_____

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

_____

PATIENT CONSENT- PLEASE PRINT

Patient's Name_____ Date of Birth_____

INFORMED CONSENT FOR CHIROPRACTIC CARE AND X-RAYS

A patient, in coming to the chiropractor, gives the doctor permission and authority to care for the patient in accordance with chiropractic test, x-rays, diagnosis, and analysis, The Chiropractor adjustment or other clinical procedures are beneficial and extremely rarely cause any problem, In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The, doctor, will not give a chiropractic adjustment, or other health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor, The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractor provides a specialized non-duplicating health care service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I hereby authorize an office evaluation and x-rays to be performed if necessary. Should I choose to become a patient in this Chiropractic office, I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Attention Females Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and the Doctor and his/her associates have my permission to perform x-rays. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual period._____

Patient Signature _____ Date_____

Parent Signature for Minor_____ Date_____

Acknowledgement of Receipt

By signing this form, I acknowledge that I received or was offered the Privacy Notice and understand that my protected health information may be used by Fairwood Family Chiropractic as described in the Notice.

I,_____, hereby authorize Fairwood Family Chiropractic to release private medical information to or discuss my care with the following person(s). (Example: spouse, child, power-of-attorney, caretaker, family member)

_____ _____

_____ _____

_____ _____ _____ _____

Patient Signature Date Signature of Authorized Representative Date

Vertebral Subluxations can cause pain

(*Subluxations are a form of nerve pressure which can cause serious health problems*)

1. Which pain or condition have you marked the worst?
   _____

2. How long has it bothered you?
   _____

3. Vertebral Subluxations can cause irritation to different fibers within nerves. Are your pains sharp or dull?
   _____

4. Subluxations can put pressure on the spinal cord which can be constant or occasional. Which do you feel?
   _____

5. Pressure on the spinal cord or nerves can be worse in the AM or PM. Which is worse for you?
   _____

6. Does this pain radiate into an extremity (arm or leg) yet or stay in one area?
   _____

You are finished with your paperwork; please double check to make sure each page is completed fully and accurately. Please let the front desk know that you have completed your paperwork. Thank You!