FULL POTENTIAL CHIROPRACTIC

2410 Hog Mountain Rd. #301, Watkinsville, GA 30677 706.403.2332 fpchiro.com
(1/2 mile from Butler's Crossing in Oconee Meadows Office Park)

Name_____ Date____/____/____ DOB____/____/____ Age:____ Sex: M/F

Address_____City_____State_____Zip_____

Phone: Cell _____ Home_____ Business_____

Email Address_____

Occupation_____ Employer_____

Single / Married / Divorced / Widowed / Partnered Spouse's Name_____

Number of Children_____ Names & Ages _____

Emergency Contact_____ Phone #_____

Do you have insurance? YES / NO If YES, please bring your insurance card with you on your first visit.

How did you learn about our office? _____

Previous Chiropractic Care? YES / NO Approximate Last Visit Date _____

Use one box per health concern below to describe condition. Please be sure to fill out each box completely.

Health Concern #1:

_____

Pain Level Now: 0 1 2 3 4 5 6 7 8 9 10
Pain at Its Worst: 0 1 2 3 4 5 6 7 8 9 10

When did it start? _____
Better: Ice Heat Rest Movement Stretching Medication _____
Worse: Sit Stand Walk Lying Sleep Bending Working Overuse All
Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Radiate: N / Y Where?: _____
Frequency: Constant Off/On Episodes per week/month: _____

Health Concern #2:

_____

Pain Level Now: 0 1 2 3 4 5 6 7 8 9 10
Pain at Its Worst: 0 1 2 3 4 5 6 7 8 9 10

When did it start? _____
Better: Ice Heat Rest Movement Stretching Medication _____
Worse: Sit Stand Walk Lying Sleep Bending Working Overuse All
Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Radiate: N / Y Where?: _____
Frequency: Constant Off/On Episodes per week/month: _____

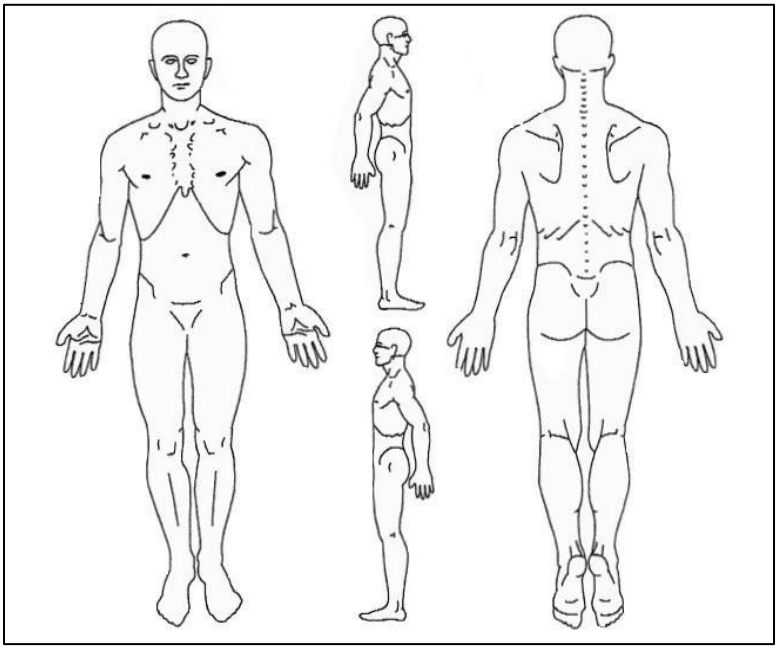
Health Concern #3:

_____

Pain Level Now: 0 1 2 3 4 5 6 7 8 9 10
Pain at Its Worst: 0 1 2 3 4 5 6 7 8 9 10

When did it start? _____
Better: Ice Heat Rest Movement Stretching Medication _____
Worse: Sit Stand Walk Lying Sleep Bending Working Overuse All
Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Radiate: N / Y Where?: _____
Frequency: Constant Off/On Episodes per week/month: _____

Place an "X" on each area of pain.



FAMILY HISTORY:

Heart Disease: Mother / Father / Sibling / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Stroke: Mother / Father / Sibling / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Cancer: Mother / Father / Sibling / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Any other family history that might be relevant: _____

_____

_____

PAST HEALTH HISTORY (List even if it was 20+ years ago):

Surgeries (Type, Reason & Dates): _____

_____

_____

Major Injuries/Traumas/Broken Bones/Car Accidents (Dates): _____

_____

_____

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

❑ Headache ❑ Neck Pain ❑ Dizziness ❑ Nausea/Vomiting ❑ Light Headed/Fainting

❑ Difficulty Speaking ❑ Difficulty Swallowing ❑ Difficulty Walking ❑ Double Vision

❑ Rapid Eye Movement ❑ Numbness/Weakness on One Side of Face/Body

❑ THERE IS A CHANCE I MAY CURRENTLY BE PREGNANT.

Glandular System:
- ☐ Chronic Fatigue
- ☐ Migraines
- ☐ Bad Acne
- ☐ Low Immunity
- ☐ Mental Fog
- ☐ Hot Flashes
- ☐ Hypo/Hyper Thyroid
- ☐ Diabetes
- ☐ Poor Memory
- ☐ Infertility
- ☐ Erectile Dysfunction
- ☐ Irregular Periods
- ☐ Prostate Problems
- ☐ Tonsillitis/Adenoid Issues
- ☐ Fibromyalgia
- ☐ Poor Appetite
- ☐ Autoimmune Disease
- ☐ Low metabolism
- ☐ Sleep Problems

Nervous System:
- ☐ Vision Problems
- ☐ Balance Problems/Dizziness
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Loss of Smell
- ☐ Concussion
- ☐ Tremors
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Depression
- ☐ Hormonal Imbalances
- ☐ Numbness in Arm/Hand
- ☐ Numbness in Leg/Foot
- ☐ Sciatica
- ☐ Loss of Coordination
- ☐ Memory Loss
- ☐ Seizures
- ☐ Weak Immunity
- ☐ Muscle Atrophy

Muscular System:
- ☐ Balance Issues
- ☐ Postural Distortions
- ☐ Scoliosis
- ☐ Joint Pain/Stiffness
- ☐ Arthritis
- ☐ Inflammation
- ☐ Muscle Spasms
- ☐ Muscle Cramps
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Hip Pain
- ☐ Leg Pain
- ☐ Plantar Fasciitis
- ☐ Degenerative Discs
- ☐ Disc Herniations
- ☐ Stenosis
- ☐ Knee Pain

Eliminative System:
- ☐ Allergies/Congestion
- ☐ Sinus Issues
- ☐ Asthma
- ☐ COPD
- ☐ Shortness of Breath
- ☐ Hives/Rash
- ☐ Psoriasis
- ☐ Kidney Stones
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Sore Throat
- ☐ Bladder Infections
- ☐ Urinary Tract Infections
- ☐ Diverticulitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Crohn's Disease

Digestive System:
- ☐ Food Sensitivities
- ☐ Food Allergies
- ☐ Weight Problems
- ☐ Heartburn/Acid Reflux
- ☐ Diabetes
- ☐ Pancreatitis
- ☐ Anemia
- ☐ Gall Stones
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Malabsorption
- ☐ Ulcers
- ☐ Gas/Bloating
- ☐ Stomach Cramps
- ☐ Low Grade Headaches
- ☐ Vomiting
- ☐ Digestive Problems
- ☐ Loss of Taste

Circulatory System:
- ☐ High/Low Blood Pressure
- ☐ Arrhythmias
- ☐ Palpitations
- ☐ Migraines
- ☐ A-Fib
- ☐ Poor Circulation
- ☐ Angina
- ☐ Heart Attack
- ☐ Edema
- ☐ pH Imbalance
- ☐ TIA
- ☐ Stroke
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Vascular Disease
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Poor Wound Healing
- ☐ Lymph Node Issues

Informed Consent for Chiropractic Care

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays).

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered using hand or instrument. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

- Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.
- The Notice of Privacy Practices for Protected Health Information will be available in the office. This notice is effective as of today's date and will expire seven years after the date upon which the record was created.
- I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Full Potential Chiropractic does not accept assignment of insurance benefits.
- If my case is accepted by Full Potential Chiropractic, chiropractic adjustments will be performed in our adjusting area, where others may be receiving adjustments. I understand and consent to this form of care.
- I consent to receive reminders of appointments, events, newsletters, birthday cards, or welcome cards.
- I consent to have my spouse/significant other present during my report of findings.
- We may mail health articles, newsletters and other information directly to your home or email.
- We may leave a message at your home with someone or on an answering machine.
- Should you share a written testimonial with us, we may display it in binders or use it in our advertising. Our office will receive direct or indirect remuneration from our marketing activities. This notice is effective as of today's date and will expire seven years after the date on which you last received services from us.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

<u>Consent to Evaluate and Adjust a Minor Child:</u>

I, _____, being the parent or legal guardian of

_____ have read and fully understand the above Informed Consent and

hereby grant permission for my child to receive chiropractic care, even when I am not present to observe such care.

_____ _____

Signature Date