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____/____/____Age_____ Male/Female

Address_____City_____State_____Zip_____

Phone: Cell _____ Home_____ Business_____

Email Address_____ Date of Birth_____/_____/_____

Occupation_____ Employer_____

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

Number of Children_____ Names & Ages _____

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: _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	When did this episode start?	What makes the condition better?	What makes the condition worse?	Rate of Severity 1 - mild 10 - unbearable	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

□ I have no health concerns, but I am interested in natural health care and want to have my spine & nerve system checked

PLEASE CIRCLE ALL PROBLEMS YOU HAVE HAD IN THE PAST 2 YEARS:

DIZZINESS	*THROAT ISSUES*	*KIDNEY PROBLEMS*	*BREATHING PROBLEMS*	*NERVOUSNESS*
HEADACHES	*THYROID PROBLEMS*	*MID BACK PAIN*	*SHOULDER PAIN*	*SEIZURES*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*ULCERS*	*SCIATICA*	*LUPUS*	*INFERTILITY*
NAUSEA	*NUMBNESS IN ARMS*	*NUMBNESS IN LEGS*	*FIBROMYALGIA*	*HIGH BLOOD PRESSURE*
TMJ	*NUMBNESS IN HANDS*	*NUMBNESS IN FEET*	*CHEST PAIN*	*DIFFICULTY SLEEPING*
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*OTHER*_____
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	_____
ANXIETY	*DIGESTIVE PROBLEMS*	*LEG PAIN*	*ALLERGIES*	_____
SINUS PROBLEMS	*BLADDER PROBLEMS*	*KNEE PAIN*	*ACID REFLUX*	_____

CIRCLE ANY CONDITION YOU HAVE NOW / HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND DATES:

_____

_____

LIST ALL FRACTURES OR BROKEN BONES AND DATES:

_____

_____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT?_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA:

_____

_____

STRESS:

The following areas of stress can cause misaligned vertebrae (subluxation). Which of these stresses do you recognize from your life currently or from your childhood?

Physical/Emotional/Chemical Stress:

□ Birth Trauma
□ Car Accidents
□ Physical Abuse
□ Work Injuries
□ Sleeping on Stomach
□ Carrying Heavy Purse/Backpack/Child
□ Driving for Many Hours
□ Children Stress
□ Relationship Stress
□ Quick Tempered
□ Poor Diet/Excessive Sugar
□ Artificial Sweeteners
□ Over-the-Counter Drugs (ex. Tylenol/Motrin)
□ Slips/Falls
□ Sports Injuries
□ Poor Posture
□ Sitting on a Wallet
□ Extensive Computer Work
□ Repetitive Lifting/Bending
□ Continuous Hours Sitting/Standing
□ Career Stress
□ Concealed Feelings
□ Smoker/Second Hand Smoke
□ Caffeine
□ Prescription Drugs

○ ***THERE IS A CHANCE I MAY CURRENTLY BE PREGNANT.***

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING PAST
HEALTH HISTORY INFORMATION FOR HIS REVIEW.

_____

PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

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 post pictures of our "Chiropractic Kids" and "Chiropractic Families" on the walls.
- 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