WELCOME TO NORMAN FAMILY CHIROPRACTIC

ADULT FORM

Name:	**Age:**	**Date of Birth:**
Address: (Street, City, State & Zip)		
Phone: (Home)	**(Work)**	**(Cell)**
Email Address:	**Employer:**	
Sex: □ Male □ Female	**Marital Status: □ Single □ Married □ Widowed □ Divorced**	
Spouse's Name:	**Spouse's Occupation:**	
How many children do you have?		
Names & Ages of Children:		
How did you hear about Dr. Norman?		
Have you ever consulted a Doctor of Chiropractic?		
If yes: Who?	**When?**	**How long were you under care?**
Did you receive: X-rays (when)?	**MRI (when)?**	

Please list your occupation and describe what type of work you do daily:

_____

_____

_____

Please describe what brought you into our office today:

_____

_____

_____

The statements made on this form are accurate to the best of my recollection, and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered.

X _____ _____

Signature **Date**

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ADULT FORM

Do you now, or have you ever suffered from:

□ Dizziness	□ Heart trouble	□ Diabetes	□ Lung problems
□ Asthma	□ High blood pressure	□ Neuritis	□ Digestive disorder
□ Heart burn	□ Headaches	□ Arthritis	□ Sinus trouble
□ Cancer	□ Nervousness	□ Anemia	□ Trouble Sleeping
□ Low Energy	□ Poor Circulation	□ Anxiety	□ Tingling in hands/feet
□ Allergies	□ Tire easily	□ TB	□ Numbness in hands/feet
□ Irritability	□ Depression	□ Tumor	□ Menstrual pain or difficulties

Please list any other health concerns you have at this time:

_____

_____

Physical Stressors

List any accidents or injuries:
List childhood injuries:
List any broken bones:
List any surgeries:
List any other medical procedures:
Do you do any physical activity on a daily basis? If yes, what type?

Chemical Stressors

List any and all Prescriptions and OTC drugs:
Do you drink coffee or caffeinated beverages? How often?
Do you smoke or chew tobacco? Do you drink alcohol? How often?

Emotional Stressors:

Have you had any strong emotional stressors recently or in the past?

INFORMED CONSENT TO TREATMENT

In an effort to encourage and support a shared decision making process between us regarding your health needs, Norman Family Chiropractic provides the following information:

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/are 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.

In addition to the benefits of chiropractic care, 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.

1. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture.
2. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE THESE RISKS

I hereby consent to the chiropractic treatment as indicated, needed and explained to me. If during the course of treatment unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and treatment as may be indicated by sound and prudent chiropractic practice.

No guarantee or warranty has been offered to me that results will be to my complete satisfaction.

IF YOU HAVE ANY QUESTIONS ABOUT THIS, PLEASE ASK YOUR CHIROPRACTOR.

I HAVE READ THE ABOVE, UNDERSTAND AND CONSENT TO TREATMENT.

Signature: _____ Date: _____

Witness: _____ Date: _____

Norman Family Chiropractic

Please Sign All That Apply

PREGNANCY RELEASE (ALL WOMEN)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

_____ _____

Patient Signature **Date**

CONSENT TO EVALUATE / ADJUST A MINOR CHILD

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and herby grant permission for my child to receive examination and chiropractic care as deemed necessary.

_____ _____

Patient Signature **Date**

CONSENT TO X-RAY

I hereby authorize Norman Family Chiropractic & Wellness, or whoever the clinician may designate to take x-rays.

_____ _____

Patient Signature **Date**

PRIVACY NOTICE

The practice may use and/or disclose my protected health information in order for the practice to treat me and obtain payment for that treatment and as necessary for the practice to conduct its specific health care operations. I understand that the practice utilizes an open adjusting room format to conduct patient treatment.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Patient Signature **Date**

3740 N Josey Lane, Suite 216, Carrollton, TX 75007 (972) 394-3350 Fax (972) 395-3628

HEALTH ASSESSMENT:

NAME: ..... ***Today's Date: _ _ /_ _ /_ _ _ _***

This is a questionnaire that assists you to "quantify" your general health: Think of your health over the last month and tick inside the box which most closely corresponds to how you feel about each description in both the regularity and severity sections. (i.e. You will have two ticks in each row next to each description, one for regularity and one for severity.)

	REGULARITY					SEVERITY				
	Never	Rarely	Sometimes	Often	Always	None	Mild	Moderate	Severe	Unbearable
Aches and pains										
Angry or frustrated										
Asthma, cough or breathing problems										
Bad posture										
Concentration or thinking problems										
Dissatisfied with appearance or shape										
Feel isolated or lonely										
Feel sick or unwell										
Headaches										
Health affects family or relationships										
Heart, circulation or chest problems										
Hormonal, menstrual or sexual difficulties										
Infections or allergies										
Low energy or fatigue										
Make bad dietary choices										
Make bad lifestyle choices										
Nausea, reflux or digestive problems										
Not enough exercise										
Pains in hands, feet, arms &/or legs										
Poor fitness level										
Really tired on days off										
Restricted in basic daily activities										
Restricted in work or recreational activities										
Sad, depressed, unhappy or upset										
Take over the counter medication										
Take prescription medication										
Tummy or abdominal pains or problems										
Unhappy at home &/or work										
Vomiting, constipation or diarrhea										
Multiply # in each column	0	1X _ =	2X _ =	3X _ =	4X _ =	0	1X _ =	2X _ =	3X _ =	4X _ =
SUBTOTAL										
TOTAL										