CURRENT HEALTH HISTORY Date:_____

Name_____ DOB_____ Age:___ □ Male □ Female

Address_____City_____State_____Zip_____

Home Phone _____Work Phone_____Cell Phone _____

SS #_____-_____-_____ Email_____

WELCOME BACK! We're glad you returned for care. Let us know how we can help (check all that apply):

- I have no complaints & would like to start a wellness program.
- I have a similar complaint as last time.
- I have a new complaint unrelated to last time.
- I would like to 'correct' my complaint and then continue on with wellness care.
- I would like to 'correct' my complaint and then stop care.
- I would like a few adjustments to feel better and then stop care.

SINCE YOUR LAST VISIT…

1) Have there been any changes to your health? YES NO Explain_____

2) Have there been any changes to your family history? YES NO Explain_____

3) Have there been any traumas, accidents or surgeries? YES NO Explain_____

Please indicate in order of importance ALL complaints you are experiencing and briefly describe.

1st Complaint_____ It's getting: Better Worse No Change

a. Been a problem for: (please specify #) ____Day(s) ____Week(s) ____Month(s) ____Year(s) ***Mark areas below***

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

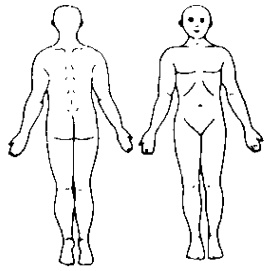
c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM In Bed Does it radiate? Yes No Where:_____

f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

g. What makes it better?_____What makes it worse?_____



2nd Complaint_____ It's getting: Better Worse No Change

a. Been a problem for: (please specify #) ____Day(s) ____Week(s) ____Month(s) ____Year(s) ***Mark areas below***

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

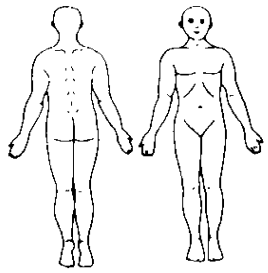
c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM In Bed Does it radiate? Yes No Where:_____

f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

g. What makes it better?_____What makes it worse?_____



<u>Wellness Profile:</u> Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve. *(Circle as many goals as you wish)*

More Energy	Better Sleep	Freedom from Pain
Easier Breathing	Improved Posture	Improved Nutrition & Diet
Improved Coordination	Eliminate Medications	Improved Overall Health
Better Sports Performance	Stress Reduction	Better Concentration
Stronger Immune System	Other_____	

Continued on back…

ACTIVITIES OF DAILY LIVING - In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

		0	1	2	3	4
1)	**Pain Intensity:**	None	Mild	Moderate	Severe	Unbearable
2)	**Frequency of Pain:**	None	25% of the day	50% of the day	75% of the day	Constant
3)	**Lifting:**	No Pain w/ Heavy Weight	Increased Pain w/ Heavy Wt.	Increased Pain w/ Moderate Wt.	Increased Pain w/ Light Wt.	Increased Pain w/ Any Wt.
4)	**Walking:**	No Pain w/ Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain w/ Any Distance
5)	**Standing:**	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain w/ Any Standing
6)	**Travel:** (Driving)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
7)	**Work:**	Do Usual Work + Unlimited Extra	Do Usual Work But No Extra	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
8)	**Sleeping:**	Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Severely Disturbed	Totally Disturbed
9)	**Personal Care:** (Washing, Dressing, etc.)	No Pain	Mild Pain	Moderate Pain	Severe Pain	Unbearable Pain
10)	**Recreation:**	Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activities

Score:_____

Fees & Care Plans:

Exam = $80 -$95 X-rays = $75/set Adjustments = $45-$60

Insurance: We used to be 'in network' with many insurance companies however we found being 'out of network' offered most of our patients' *better* coverage and *fewer* restrictions. We can work with most insurance companies to submit claims electronically on your behalf. Currently we are ***'in network'*** with **Medicare** and are considered ***'out of network'*** for **all others**. You may call the (800) number on the back of your card to check your coverage; however, we will call to verify your chiropractic benefits and discuss them with you on your second visit.

MEDICARE – Medicare has chiropractic coverage; however, they **DO NOT** contribute towards ***exams or xrays***.

MEDICAID – Medicaid **DOES NOT** offer ANY chiropractic benefits. Fees listed above will be your full financial responsibility.

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care whether or not paid by insurance. If I have insurance, I authorize and assign all insurance benefits payable to me for services rendered if BC Family Chiropractic accepts assignment on my behalf. I authorize use of my signature below on all insurance submissions. Copies of any x-ray reports will be released upon written request; however, the original films are the sole legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 years. The above information is true and accurate to the best of my knowledge.

Patient Name	Patient Signature (Parent / Guardian)	Date	Dr. Initials

Informed Consent for Female Patients: By signing below I acknowledge that I understand the hazardous effects of x-rays to an unborn child and that I am not pregnant to the best of my knowledge. The first day of my last menstrual cycle was on _____. I hereby consent to have any diagnostic x-ray exam the doctor deems necessary.

Patient Signature	Date	Dr. Initials

BC FAMILY CHIROPRACTIC, PC
365 HARRY L. DRIVE
JOHNSON CITY, NY 13790
(607) 754-5900 / (607) 217-5257 (fax)

Informed Consent

We encourage and support a **shared decision making process** 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.

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 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/or 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 but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. 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. 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.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE BC FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**

PARENTAL CONSENT FOR MINOR PATIENT:

Patient Name: _____ age: ____ DOB: _____ Relationship to patient_____

_____ _____	_____	_____
Parent / Legal Guardian Name	**Parent / Guardian Signature**	**Date**

CONSENT TO TREAT WITHOUT A PARENT / GUARDIAN PRESENT:

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

_____	_____	_____
Parent / Legal Guardian Name	**Parent / Guardian Signature**	**Date**