FULLER CHIROPRACTIC
HEALTH & WELLNESS

CONFIDENTIAL HEALTH RECORD

Date:_____

Full Name:_____

DOB:_____ Cell Phone #:_____ Home Phone #:_____

Address:_____ City/State/Zip:_____

Email:_____ Employer:_____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed Emergency Contact:_____

Phone #:_____ Relationship to Patient:_____

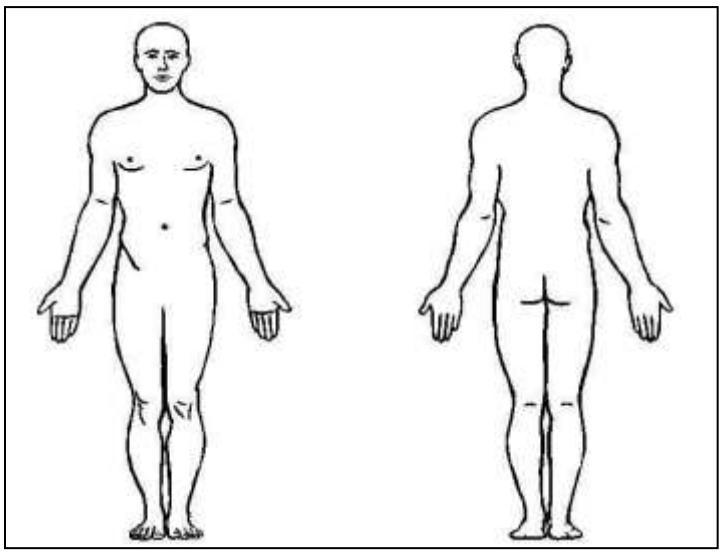
Insurance Company:_____ Are you the Insured on the policy? ☐ Yes ☐ No (If Yes, skip next)

Insured Name:_____ Insured D.O.B.:_____ Relationship to Patient:_____

Presenting Condition

Mark the area of pain/sensation using the appropriate symbols listed below. Please be as specific as possible.

/// Sharp Pain
XXX Burning
(((Aching Pain
000 Pins & Needles
::: Numbness



Describe your pain/sensation:_____
_____
_____
_____
_____
_____
_____
_____
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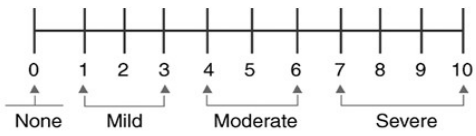
_____
_____
_____
_____
_____



Rate your pain on the Visual Analog Scale using 0 as No Pain and 10 as Intolerable.
Rate of Pain:_____
Date of Onset:_____

What makes your pain better?_____
_____
What makes your pain worse? _____
_____

Indicate your ability to perform the following activities using the following codes: **U – Unable P – Painful D – Difficult N – Normal**

1._____ Lying on Back	5._____ Lying Flat on Stomach	9._____ Pulling	13._____ Bending Forward
2._____ Lying On Side w/ Knees Bent	6._____ Standing (Over 1 Hour)	10._____ Reaching	14._____ Balancing
3._____ Turning Over in Bed	7._____ Walking Short Distances	11._____ Gripping	15._____ Dressing Self
4._____ Sleeping	8._____ Climbing	12._____ Kneeling	16._____ Getting In/Out of Car

Past Medical History

Do you suffer from any other conditions? (Diabetes, High Blood Pressure, Arthritis, Heart Disease, etc.) If yes, please list:

_____

Have you been diagnosed with osteoporosis? ○ Yes ○ No
Do you have metal implants? ○ Yes ○ No
Have you been diagnosed with spinal stenosis? ○ Yes ○ No
Have you been diagnosed with cancer? ○ Yes ○ No
Have you had spinal surgery? ○ Yes ○ No

Have you ever become dizzy or lost consciousness when turning your head? ○ Yes ○ No
Have you ever had a sudden weakness in the arms or legs? ○ Yes ○ No
Have you ever had numbness in the genital area? ○ Yes ○ No
Have you had a recent inability to urinate or lack of control when urinating? ○ Yes ○ No
Do you take Warfarin (Coumadin), Heparin, or other similar "blood thinner"? ○ Yes ○ No

Please list all prescription medications, over the counter medications, vitamins, and supplements you are currently taking:

_____

_____

Have you ever consulted a Chiropractor? ○ Yes ○ No If yes, list date, doctor's name, condition, and any complications:

_____

Have you consulted an MD for this condition? ○ Yes ○ No If yes, list date, doctor's name, results, and any complications:

_____

Have you had any major illnesses, injuries, falls, hospitalizations, auto accidents or surgeries? ○ Yes ○ No

If yes, list date, injury/illness, and treatment:_____

_____

Have you had any x-rays taken of your spine? ○ Yes ○ No Date and where taken:_____

FEMALES: Date of last gynecological and breast exam:_____ Are you pregnant: ○ Yes ○ No

MALES: Date of last prostate and testicular exam: _____

Social Health History

Recreational activities (Hobbies):_____

Job Description:_____ Work hours per week:_____ How far do you commute to work?_____

Are you a student? ○ Yes ○ No If Yes, are you full time or part time?_____

Do you exercise? ○ Yes ○ No Times per week?_____ Do you smoke? ○ Yes ○ No How much per day?_____

Do you consume caffeine? ○ Yes ○ No How much per day?_____ Do you consume alcohol? ○ Yes ○ No How much per week?_____

Family Health History

Health Status of Family Members (If deceased, please explain)

Mother:_____

Father:_____

Brothers/Sisters:_____

Children:_____

System Review Questions

Have you had any problems with the following area? (Please mark Y- Yes or N- No for each of the following)

1._____Eyes
2._____ Ears, Nose, Mouth, Throat
3._____ Heart
4._____ Lungs/Breathing
5._____ Intestines/Colon
6._____ Internal Organs
7._____ Muscles
8._____ Nerves
9._____ Skin
10._____ Urinary
11._____ Blood
12._____Psychological
13._____Allergies (Please list)
_____
14._____Other (Please list)
_____

My signature is an acknowledgement that all of the above statements are true.

_____ _____

Patient/Guardian/Responsible Party Signature Date

Informed Consent For Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic therapies, treatments, and procedures by Garry T. Fuller, D.C., PC.

1. I understand that chiropractic care is the science, philosophy and art of locating and correcting spinal subluxations (misalignments) and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in the clinic.
2. I understand that the chiropractor will us his hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".
3. As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.
4. It is not reasonable to expect my chiropractor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.
5. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.
6. As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. These complications are extremely rare occurrences.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to chiropractic treatment and any other therapy deemed appropriate for my care.

_____ _____

Patient Name (Printed) Patient/Guardian/Responsible Party Name (Printed)

_____ _____

Patient Signature (Parent/Guardian/Responsible Party Signature) Date

_____ _____

D.C./C.A. Signature Date

FULLER CHIROPRACTIC CLINIC

FINANCIAL POLICY

Whether you are new to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policy. *Please read this information carefully- front and back sides- sign on the reverse, and turn in to the receptionist.* We will be happy to give you a copy to keep for your records.

SIGN-IN: At each visit we ask that you sign in your real name and update any personal information that may have changed since your last visit (address, phone number, etc.) along with your insurance information. Please bring your insurance card to each visit.

PATIENT RESPONSIBILITY BALANCES: You will be responsible for the following:

Services not covered by insurance
Co-pays and balances remaining after your insurance company has paid, including deductibles and co-insurances. (Percentage that is your obligation)

Payment in full is expected within 30 days from your first statement advising you of the balance due.

INSURANCE: We participate in Medicare and Sagamore PPO networks, but cannot know the details of the coverage and benefits for your policy. Therefore, you will need to be familiar with your policy and know what is required to access chiropractic care. You have to be aware of the following requirements:

Network participation of providers
Annual deductibles that apply
Co-pay that must be paid each visit
Limitations that may be listed for your treatment

If you are unsure of these requirements, contact your insurance representative before your visit. We will make one attempt to call your insurance company for coverage; however we cannot be responsible for misquoted benefit information. It is your responsibility to advise us of any insurance changes at the time of service. Any billing errors resulting in non-payment of your claims will be the responsibility of the patient and/or guarantor.

SELF-PAY and SERVICES NOT COVERED BY INSURANCE: If you do not have insurance or we are not contracted with your insurance plan, you will be expected to pay at the time of service. Not all services are covered by all insurance policies. Some insurance policies arbitrarily select certain services that will not be covered. Non-covered services will be the financial responsibility of the patient and/or guarantor.

MEDICAL CARE TO MINORS: If both parents have insurance, the insurance of the parent whose birthday falls first in the calendar year will be considered primary for the child, and the other parent's insurance will be secondary. When the parents are divorced, we will consider the parent/legal guardian who presents a child for care to be the responsible party for payment of services, regardless of financial responsibility established in a divorce decree. Further, care for a patient under 18 years of age must be authorized by a parent, legal guardian, or someone to whom you give written authorization to present the child for care.

MOTOR VEHICLE ACCIDENTS: If your condition results from a motor vehicle accident, we will bill *your* auto insurance for any charges you may incur resulting from that accident. We will treat your account as any other and we will consider you, not your insurance to be the responsible party for all fees, in the event of non-payment. As stated before, payment in full is expected within 30 days from your first statement advising you of the balance due.

PAYMENT METHODS: For your convenience, in addition to cash or personal check, we also accept VISA and MasterCard. Our office also offers a program called Care Credit. For more information regarding Care Credit please inquire at the front desk.

PATIENT ASSIGNMENT, LIEN AND POWER OF ATTORNEY: If we are billing your insurance you hereby direct all insurers to make all payment for your health care services directly to Fuller Chiropractic Clinic. In the event that your insurance sends the payment directly to you, you agree to immediately deliver said payment to Fuller Chiropractic Clinic. We will at that time apply the proceeds from said check to your balance. By signing this agreement you also give our office permission to act on your behalf with full power of substitution for you and in your name to ask, demand, sue for, collect, endorse, sign and receive proceeds from your insurance or any third party.

ACKNOWLEDGEMENT AND AUTHORIZATION: I have read, understand and agree to the above policies. Regardless of any insurance I may have, I am ultimately responsible for payment for any professional services rendered. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Fuller Chiropractic Clinic. If my account should become delinquent, I agree to pay the costs of collections, including legal fees and court costs.

The assignments and agreements contained in this document may not be revoked by the patient without the expressed written consent of the Provider.

Signature_____Date_____

Patient and/or responsible party