

Family Healthcare Chiropractic Center, Inc.

Welcome to our office.

Please fill out the following information as completely as possible.

PATIENT INFORMATION

(Please Print Clearly)

Legal First Name: _____ Nickname _____ MI: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ - _____ - _____ Work #: _____ - _____ - _____ Cell #: _____ - _____ - _____

E-Mail Address: _____

(We do not share your address with anyone. We use e-mail to send appointment reminders, to notify you of last minute office closures, and other general FHCC information/newsletters.)

Sex: M F Date of Birth: _____ Age: _____ Soc.Sec.#: _____ - _____ - _____

Marital Status: Single Married Divorced Widowed

Occupation: _____ Employer Name _____

Spouse's Name: _____ Spouse's Employer: _____

Name and age of children: _____

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? No Yes (immediately notify front desk) Your Initials: _____

If yes: Date of Accident: _____ Time of Accident _____ Claim #: _____

Pregnant: Yes No Pacemaker: Yes No Family Physician _____

Emergency Contact (Name, Phone # and relationship) _____

How did you hear about us:

- Internet/Website Stafford Red Book Fredericksburg Yellow Pages Woodbridge/Stafford Yellow Pages
 Welcome to the Neighborhood Mailer Referred by _____ Other _____

Previous Chiropractic Care:

No Yes (When & Where) _____

Signature of Patient/Guardian: _____ Date: _____

INSURANCE INFORMATION

Do you have health insurance: No Yes If yes, please provide us with your card so that we may make a copy of it.

If your name is not on the insurance card, please fill out the information below for the person listed on the card.

Sex: M F Date of Birth: _____ Soc.Sec.#: _____ - _____ - _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ - _____ - _____ Cell #: _____ - _____ - _____ Work #: _____ - _____ - _____

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA): No Yes. If yes, what is the remaining balance in the account: \$ _____

IRREVOCABLE ASSIGNMENT, AUTHORIZATION AND LIEN

With this Irrevocable Assignment, Authorization and Lien (this "Assignment"), and in consideration of treatment without having to render concurrent payment, I, the undersigned patient, hereby irrevocably transfer set over and assign to Dr. Thomas Genovese (the "Health Care Provider") all insurance and/or litigation proceeds to which I am now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the undersigned by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorneys' fees, and I further hereby irrevocably authorize and direct any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from me and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to me or on my behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the undersigned, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in my favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the undersigned. This Assignment is to be a complete and current transfer of my right, title and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled.

The undersigned patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is to act as a full, immediate and complete assignment of all of the undersigned's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Provider's total claim amount; therefore, I hereby irrevocably assign and transfer to the Health Care Provider any and all causes of action that I might have or that might exist in my favor against such insurance company and/or attorney and authorize, and nominate and appoint as my attorney-in-fact any officer, of the Health Care Provider, to prosecute said cause(s) of action either in my name or in the Health Care Provider's name and further I authorize the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

I hereby further give a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the undersigned as a result of the injuries or illness for which I have been treated by said Health Care Provider. The undersigned patient further agrees that the Health Care Provider's statute of limitations on its right to demand payment from the undersigned patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the undersigned patient are ongoing.

Notwithstanding the foregoing, the undersigned patient agrees that until the Health Care Provider is paid in full, the undersigned shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The undersigned further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect of payment, it may demand payments from me immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

I authorize the Health Care Provider to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. I hereby nominate and appoint any officer of the Health Care Provider as my attorney-in-fact to endorse/sign my name on any and all checks for payment of any indebtedness owed by me to the Health Care Provider and to negotiate same for payment of the services provided to me by said Health Care Provider.

A photocopy of this document is to be considered as valid as the original. I have read and fully understand the above.

Witness my signature and seal as of the indicated date:

Printed Name _____ Date _____

Signature _____ Witness _____

Your Health Profile

Why This Form Is Important

As a general focus chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Childhood (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

(Y=Yes; N=No; U=Unsure)

- Did you have any childhood illnesses? _____
- Did you play youth sports? _____
- Did you have any surgeries? _____
- Involved in any car accidents as a child? _____
- Prolonged use of medicines? _____
- Any other traumas (physical or emotional)? _____
- If yes, please explain: _____
- Did you have any serious falls as a child? _____
- Did you take/use any drugs? _____
- Were you vaccinated? _____
- Fallen/jumped from a height over 3 feet _____
- Were you under regular chiropractic care? _____

COMMENTS _____

Adulthood (18 to present)

- Do/did you smoke? _____
- Do/did you drink alcohol? _____
- Have you been in any accidents? _____
- When was your last medical physical? ____/____/____
- Were there any concerns? No Yes (please explain): _____
- Do/did you play adult sports? _____
- Do/did you participate in extreme sports? _____
- Have you had any surgeries? _____

COMMENTS _____

On a scale of 0 ó 10 describe your stress level (0=none/10=extreme): Occupational _____ Personal _____
On a scale of Poor, Good or Excellent describe your: Diet _____ Exercise _____ Sleep _____ General Health _____

Office Notes:

Addressing The Issues That Brought You To The Office

Briefly describe the chief area of complaint and the effect it has had on your life:

If you are experiencing pain, is it: Sharp Dull Comes and Goes Travels Constant

The problem is: Getting Better Getting Worse About the same

It is aggravated by: _____

It is alleviated by: _____

It interferes with: Work Sleep Walking Sitting Hobbies Leisure Other _____

Doctors seen for this problem:

Chiropractor: _____ Medical Doctor: _____ Other: _____

Please check (✓) any of the following that you are currently experiencing or have a history of:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of balance/dizziness | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Sinus troubles |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> High/Low BP | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Menstrual trouble | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pains in legs/feet | <input type="checkbox"/> Pins/needles in arms/hands |
| <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tightness of shoulder muscles |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Pain in shoulders/arms | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Twitching of eyes | <input type="checkbox"/> Painful/swollen joints | <input type="checkbox"/> Inner tension/Irritability | <input type="checkbox"/> Pins/needles in legs/feet |

COMMENTS _____

List any medications you are taking: _____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Others: _____

Have you ever (Y=Yes; N=No):

Bought bottled water _____ Belonged to a health club: _____ Consumed vitamins/supplements: _____

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.

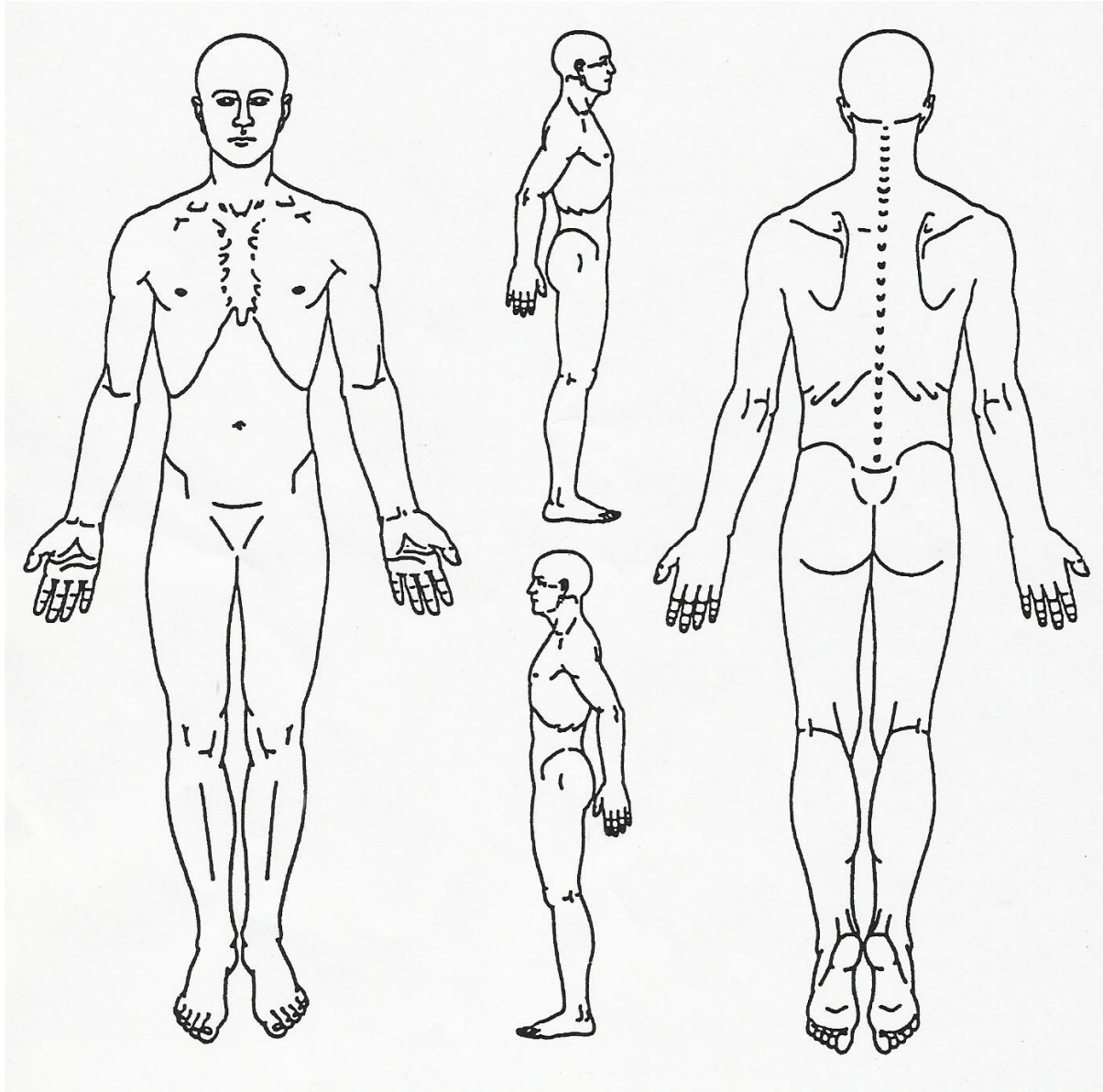
Patient Name: _____ **Date** _____

Patient Signature: _____

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a , , or , arrow to indicate the direction of radiating pain. (Include all affected areas)

A = Ache	B = Burning	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

NAME: (please print) _____

How long have you experienced neck/back pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck/back pain? _____ YES _____ NO

SIGNATURE: _____

DATE: _____