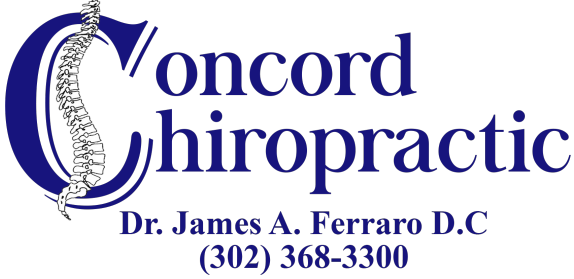

Your Health Profile

Name: _____ Date: ____/____/_____

Address: _____

Street City State Zip Code

Preferred Contact Number: (___) _____-____ This number is a: Home__Cell__Other__

Email Address: _____

**Concord Chiropractic will not use your e-mail address for anything other than appointment reminders or newsletters*

Date of Birth: _____-_____-_____ Age: _____

Occupation: _____ Employer's Name: _____

Reason for visit: _____

Who may we thank for referring you to our office? _____

The Early Years (Birth to 17)

It has been shown that many health challenges later in life have origins that date back to as early as birth. Please answer the following questions as best you can.

Did you have any childhood illnesses?
Y / N

Were you in any car accidents?
Y / N

Did you have any serious falls?
Y / N

Did you experience any birth trauma?
Y / N

Did you play youth sports?
Y / N

Did you take or use any drugs?
Y / N

Did you have any surgery?
Y / N

Did you fall/jump from a height over 3 feet?
Y / N

Was there any prolonged use of medicine such as antibiotics or inhaler? Y / N

Did you suffer any other traumas (physically or emotionally)? Y / N

Did you receive regular Chiropractic care?
Y / N

Comments or Further Information:

_____

_____

_____

Adult Life (18 to Present)

Do/Did you smoke? Y / N

Do/Did you drink alcohol? Y / N

Have you been in any accidents? Y / N

Do/did you consume caffeine? Y / N

Are you currently taking any prescription medications? Y / N

Do/did you play any adult sports? Y / N

Do/did you participate in extreme sports? Y/N

Did you suffer from any other traumas? Y/N

Do you receive regular Chiropractic care? Y/N

On a scale of 1-10, describe your stress level: (1=none / 10=extreme) Personal_____ Work_____

Please circle how you would describe your:

Diet:	Poor	Good	Excellent
Exercise:	Poor	Good	Excellent
Sleep:	Poor	Good	Excellent
Overall Health:	Poor	Good	Excellent

Please explain if “Poor” was circled:

_____

_____

_____

Comments or Further Information:

_____

_____

_____

Issues that brought you to this Office

If you have no symptoms or complaints, and are here for wellness services, please check here. _____

Please briefly describe the chief area(s) of complaint, including the effects on your life:

_____

_____

_____

_____

Please mark all symptoms you have experienced, even if they do not seem related to your current complaint:

___Headaches	___Loss of smell	___Dizziness	___Numbness in fingers/toes
___Fatigue	___Sleeping problems	___Diarrhea	___Cold sweats
___Mood swings	___Pins and needles	___Buzzing in ears	___Depression
___Stiff neck	___Constipation	___Light sensitivity	___Menstrual pain
___Fainting	___Back pain	___Ringing in ears	___Loss of taste
___Irritability	___Cold hands	___Fever	___Problem urinating
___Neck pain	___Loss of balance	___Nervousness	___Menstrual irregularity
___Upset stomach	___Tension	___Cold feet	___Heartburn
___Ulcers	___Hot flashes		

Please list any medications and their dosage you are taking, including vitamins, OTC medications, and prescriptions:

_____
_____
_____

Please list your Primary Care Physician:

_____ (_____) _____-_____

Name Phone Number

The statements made on this form are accurate to the best of my knowledge, and I agree to let this office and its doctors examine me for further evaluation.

X_____ Date:___/___/____

Patient Signature

Concord Chiropractic
Dr. James A. Ferraro D.C
(302) 368-3300

INFORMED CONSENT

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strain and sprain, fracture, dislocation, disc injuries, temporary exacerbation of symptoms, and altered blood flow to the head and brain.

My doctor has responded to all my requests for information about the proposed treatment. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to chiropractic treatment.

Print Patient's Name	Signature of Patient	Date
Print Parent/Guardian Name	Signature of Parent/Guardian	Date
Print Witness Name	Signature of Witness	Date

Concord Chiropractic
Dr. James A. Ferraro D.C
(302) 368-3300

Authorization Form

Patient Name:(print)_____ **SS#:** _____-_____-_____

RELEASE OF INFORMATION

I hereby authorize Concord Chiropractic to release medical and financial data to my insurance carriers, other medical facilities, and attorney(s).

Initials: _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered. The undersigned understands that services are rendered and charged to you (the patient) and not your insurance company. Concord Chiropractic does not accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. It is the financial obligation of the undersigned to be responsible for any charges or services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures, or any remaining balance upon completion of settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement.

Initials: _____

CONSENT FOR TREATMENT OF A MINOR CHILD

Consent is hereby given by the undersigned for Chiropractic treatment, X-Rays, Acupuncture, any diagnostic studies as ordered by the doctors, and therapies (therapeutic massage, electrical stimulation, ice/heat therapy, hydrotherapy, therapeutic exercises) performed by the technical staff of Concord Chiropractic. The undersigned states that he/she is the patient's legal guardian.

Initials: _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payments of my medical benefits otherwise payable to me to be made payable and mailed directly to Concord Chiropractic for professional services rendered. No other third party, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledged medical coverage and will send payments directly to this office.

Initials: _____

X_____ _____ ____/____/____

Patient or Guardian Signature **Relationship to Patient** **Date**