



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 participate in extreme sports?
Y/N

Do/Did you drink alcohol? Y / N

Did you suffer from any other traumas?
Y/N

Have you been in any accidents? Y / N

Do/did you consume caffeine? Y / N

Do you receive regular Chiropractic care?
Y/N

Are you currently taking any prescription
medications? Y / N

Do/did you play any adult sports? 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

Please explain if "Poor" was circled:

Exercise: Poor Good Excellent

Sleep: Poor Good Excellent

Overall Health: Poor Good Excellent

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:

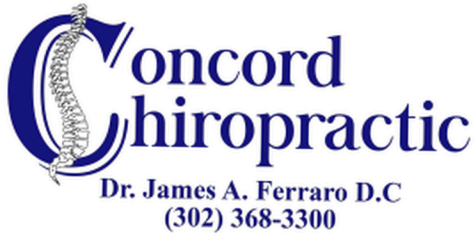
Please list your Primary Care Physician:

_____	(____) ____-____
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 _____
Patient Signature

Date: ____/____/____



Authorization Form

Patient Name:(print) _____

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



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



Release of Medical Records

Patient Name (please print): _____

Date of Birth: ____/____/____

I hereby authorize _____ to release all medical records, or those concerning the dates of treatment on _____, to:

**Concord Chiropractic
20 A Trolley Square
Wilmington, DE 19806**

These records are requested for the purpose of Medical Care. Documents requested should include:

- Discharge Summary
- History and Physical
- Operative Record
- Physician Progress Notes
- Diagnostic Tests and X-ray reports
- Other _____

I understand that this request for release of information stands effective for 120 days. This request may be revoked at any time but is not retroactive for requests that have been complied with good faith. This authorization may be revoked by written request to an authorized representative of Concord Chiropractic.

X _____
Patient's Signature Date ____/____/____

X _____
Signature of Legal Guardian Relationship to Patient Date ____/____/____

Disclosure of specific information for release is limited to the above-mentioned recipient only. Federal regulation, 42 CFR Part 2, prohibits the redisclosure of the enclosed information unless the consent expressly permits further disclosure or the redisclosure is otherwise permitted under regulations.