ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES

CASE HISTORY UPDATE

Name _____ Date: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Date of Birth _____ Age _____

Occupation _____ Employer _____

Marital Status □ S □ M □ D □ W Spouse's Name _____

Spouse's Occupation _____ # of Children/Ages _____

If pregnant, how many weeks? ___ Due Date _____Name of OB/midwife_____

Ins Co._____ Policy Number_____ Group Number _____

Subscriber's Name_____ Subscriber's Date of Birth_____

Any chiropractic care since your last visit here? Y N If yes, approx. date of last visit and Dr's name

_____

Chiropractic techniques you've had success with _____

Reason for visiting us _____

If pain, when did it start? _____

Pains are □ Sharp □ Dull □ Constant □ Intermittent Getting worse? □ Yes □ No

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? □ Yes □ No Sleep? □ Yes □ No Routine? □ Yes □ No

Other doctors seen for condition _____

Any home remedies? _____

What daily rituals for spinal health do you practice? _____

Other symptoms:

□ Headaches	□ Pins and needles in arms	□ Dizziness, fainting
□ Neck Pain	□ Pins and needles in legs	□ Loss of smell
□ Upper back, shoulder pain	□ Numbness in arms, hands, fingers	□ Loss of taste
□ Mid back pain	□ Numbness in legs, feet, toes	□ Diarrhea
□ Low back pain	□ Shortness of breath	□ Feet cold
□ Hip pain	□ Fatigue	□ Hands cold
□ Pain in arms, hands	□ Depression	□ Stomach upset
□ Pain in legs, feet	□ Lights bother eyes	□ Constipation
□ Difficulty in raising legs	□ Loss of memory	□ Loss of Balance

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(904)247-3933 or (904)479-0363

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment – An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health – A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation – A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of metal impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I hereby authorize payment directly to this office for professional services rendered and shall be personally responsible for any unpaid balance to the doctors. I hereby authorize the attending doctor to release any information concerning my examination or treatment. If an outstanding balance is not paid within 30 days, I will be responsible for all costs incurred for collections, including reasonable attorney fees.

I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Name_____Signed_____

Date_____

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Please initial **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

____ I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for four years.

Please initial **TREATMENT AUTHORIZATION**

____ I understand that if I am accepted as a patient by Alterman & Johnson Family Chiropractors, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic care will be explained to me upon my request.

____ I hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. PLEASE LEAVE THIS BLANK IF YOU ARE PREGNANT

____ I consent to receiving voicemail/text messages from Alterman & Johnson Family Chiropractors/Blooming Bellies related to my protected healthcare information at (phone number) _____. I understand I may be charged for such calls by my wireless carrier.

_____

Print Name Date

_____

Signature (Patient or Parent/Guarding)

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize of Alterman & Johnson Family Chiropractors to administer treatment as they deem necessary to my child (name)_____.

_____

Parent/Guardian Signature Date