Welcome to Amarillo Family Wellness Group

In order to serve you best we would like to know more about you and your health history.
Please print clearly and fill this out completely prior to your appointment time.

Patient Information

Date: __________________ Male/Female (circle one)
Name:____
Nickname:_____________________________________
Address:______________________________________
City:____________________ State:_______Zip:________
Birth date: ____________________________ Age:_____
Marital Status: Single Married Widowed Divorced
Social Security # _______________________________
Occupation: ____________________________________
Employer:______________________________________

Patient Family Information

Spouse Name: ___________________________________
Spouse Employer:_________________________________
Children:
Name:_________________________ Age: _____
Name:_________________________ Age: _____
Name:_________________________ Age: _____
Name:_________________________ Age: _____

Contact Information

Home Phone: ___________________________________
Work Phone:____________________________________
Cell Phone:____________________________________
Email: ______________________@_________________

Insurance

A superbill will be provided upon request for you to submit to your insurance company for reimbursement directly to you.

I hereby authorized the doctor to release all information regarding my records if needed.
Initials ____

I understand that I am financially responsible for all charges.

Initials_____

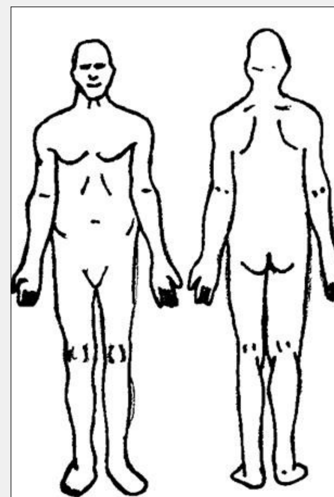
Whom May We Thank for Referring You?

____

Patient Condition

Reason for Visit: ____
When did your symptoms appear?____________________________________
Is your condition getting progressively worse?__________________________
Rate the severity of your condition: 0 (least) to 10 (worst) _________________
Type of Pain: **Sharp** **Dull** **Burning** **Throbbing** **Numbness** **Cramping** **Tight**
Frequency of Pain: **Constant** **Come and Go**
Does it interfere with: **Work** **Sleep** **Daily Routine** **Recreation**
Activities that are most painful:_____________________________________

Put an "X" on the picture where you have pain, numbness or tingling.



Health History

Have you ever seen a chiropractor before?_________ Approximate last adjustment date:__________________

Reason for the chiropractic care: ____

Names of other doctors who have cared for you: ____

Last date of Spinal Examination, X-ray, MRI, CT, or Bone Scan:_______________________________

There are many indicators for possible subluxation. Please circle any of the conditions you have suffered from in the **last 6 months**.

Depression	High Blood Pressure	High Cholesterol	Thyroid-problems	Headaches/Migraines
Sinus Issues	Heart Conditions	Breathing Problems	Digestive Problems	Bowel Problems
Urinary Problems		Liver Problems	Other:________________________	

Medications and Supplements you are taking:

____

____

Do you smoke?_________ Packs/Day______ Drink Alcohol?__________ Drinks/Week_______

Drink Coffee/Caffeine? _______ Cups/Day_____ High Stress Level (physical, mental, spiritual)? ________________

Reason:____

Other: ____

Recreational Activities you participate in: ____

Recreational Activities as a child: ____

For Women Only: Are you pregnant? Yes No Due Date:__________________

I certify that to the best of my knowledge I am not pregnant, and the doctors and staff of Amarillo Family Wellness Group have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Initial _______ Date__________________

Trauma History

Subluxation can often be caused by a slip, twist, fall, strain, accident, surgery and other traumas.
Please give us a brief description of any of these events you can think of and the dates.

Description	Date
Auto Accidents (Even if you were not driving)	
____	____________________
____	____________________
Falls/ Strains (Not limited to back injuries)	
____	____________________
____	____________________
Head Injuries/ Whiplash (Even as a child)	
____	____________________
____	____________________

Trauma history continued

	Description	Date
Broken Bones/ Dislocations		
	______________________	______________
	______________________	______________
Surgeries		
	______________________	______________
	______________________	______________
Cancer		
	______________________	______________
	______________________	______________
Any other traumas not previously listed		
	______________________	______________
	______________________	______________

I hereby authorize the doctor, and/or his associates to examine me, and to perform any necessary diagnostic procedures, including x-ray to fully evaluate my condition for the presence of vertebral subluxation.

Patient Signature______________________________ **Date**______________

(If patient is under 18, Signature of Legal Guardian)

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Topics covered are Uses and Disclosure, Your Rights, Our Duties, Complaints & Contact Information. A complete copy of this document is available upon request.

Patient Signature______________________________ **Date**______________

(If patient is under 18, Signature of Legal Guardian)

- I give permission to use my photo in the office as witness and celebration of my wellness.
- I give permission for my name to be recorded as a means for me to be called to my adjustment.
- I give permission to use my name in the office if I refer a new member to the practice.
- I understand that if I am chosen as Patient of the Week, I give permission for certain information about my case to be disclosed in the office.
- If I choose to give a testimonial of my experiences while under care, I give permission for certain information about my case to be disclosed for office purposes.

Patient Signature______________________________ **Date**______________

(If patient is under 18, Signature of Legal Guardian)

Informed Consent to Chiropractic Care

Patient: Please discuss any questions or concerns with the doctor and/ or associates.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by the doctor, his staff, and/or his associates.

The Nature Of The Chiropractic Adjustment

The doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “pop” your knuckles. You may feel a sense of movement.

The Material Risks Inherent In The Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability Of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, the doctor will look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as “rare”.

Ancillary Treatment

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

Heat ~ risk of 1st and 2nd degree burns, hemorrhage
Cryotherapy (cold packs) ~ risk of skin reactions
Trigger Point Therapy ~ risk of bruising, release of emboli
Massage ~ risk of deep vein thrombosis

The Availability And Nature Of Other Treatment Options

Other treatment options for your condition may include:

Self-administered over-the-counter analgesics and rest
Medical care with prescription drugs
Hospitalization
Surgery

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest in impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bares the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks And Dangers Attendant To Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I understand if I have any questions I am able to ask the doctors and their associates. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor’s interest) to undergo the

treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

Date: ______________________

____
Printed Name of Patient

____
Signature of Patient

Terms of Acceptance

When a patient seeks chiropractic healthcare 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 adjustment 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 alternation of nerve function and interference to the transmission of mental 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 a 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 subluxation.

I, ____ have read and fully understand the above statements.

I understand if I have any questions I am able to ask the doctors, their associates and staff.

I, therefore, accept chiropractic care on this basis.

____ ____________________________
Signature Date