Whom may we thank for referring you to this office → _____***?***

APPLICATION FOR CARE AT Ferguson *"Life"* Chiropractic Centers

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

HOW COMITTED ON A SCALE OF 1-10 TO RESOLVING YOUR CONDITIONS? 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*****:**

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

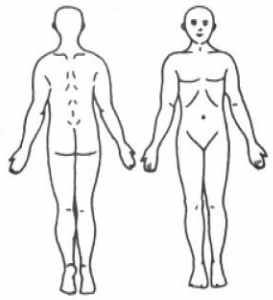
When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	

Please list any medications you presently take and for what SYMPTOMS: _____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____ _ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for ***Never have had*:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg 2- Activities of Life

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Ferguson "Life" Chiropractic Centers, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Ferguson "Life" Chiropractic Centers for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

FERGUSON "LIFE" CHIROPRACTIC CENTERS

ADJUST TO A BETTER LIFE

Policies

1. All 1st adjustment charges are payable when services are rendered.
2. X-ray film is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Ferguson "Life" Chiropractic Centers will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Ferguson "Life" Chiropractic Centers and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount. I authorize Ferguson "Life" Chiropractic Centers to obtain a credit report if deemed necessary.

Patient Signature_____
Date_____
Guardian Signature Authorizing Care_____
Date_____
In Case of Emergency Notify_____
Relationship_____
Address_____
Phone #_____

FERGUSON "LIFE" CHIROPRACTIC CENTERS

ADJUST TO A BETTER LIFE

Patient Name: _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Ferguson “Life” Chiropractic Centers, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Ferguson “Life” Chiropractic Centers.

Authorization To Release Medical Record Information

Ferguson “Life” Chiropractic Centers is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Ferguson “Life” Chiropractic Centers. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Chiropractic.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Witness: _____ Date: _____/_____/_____

Signature of Patient or Responsible Party: _____ Date: _____/_____/_____

TERMS OF ACCEPTANCE
CHIROPRACTIC INFORMED CONSENT

Patient Name: _____

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for the patient and Ferguson "Life" Chiropractic Centers to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents 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 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases 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 another health care provider.

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 God-given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Your orthopedist, family practitioner, or past chiropractor may have discussed with you various modalities of pain relief: drugs, surgery, physical therapy, manipulation, etc. We want to make you aware of how care works in this office and what is available today thanks to progress in spinal health care.

Adults: Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

Kids: Children's spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxation and begin any necessary treatment as young as possible.

Duration of Care: While pain relief may take only a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from six months to two years. Following correction, the doctor will make a recommendation for retainer care and lifetime maintenance.

As a rule, informed and cooperative patients can achieve positive Chiropractic results. Thus, the following information is routinely supplied to all who consider Chiropractic treatment. While recognizing the benefits of a healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

Family check-up: Spinal conditions are often silent and can go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do ask that all families receive a spinal check-up to discover whether significant spinal health issues exist.

Corrective care: Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.

Wellness care: Spinal neglect is so common. It has become an epidemic in our society—despite the fact that your spine and nervous system control all function and healing in your body. Getting back to maintenance is the ultimate goal of Chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.

I, _____, have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child: I, _____, being the parent or legal guardian of _____ , have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of parent/legal guardian: _____Date: _____

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____
Signature: _____Date: _____