o 615.373.7009
f 615.373.7090
136 Wilson Pike Circle
Brentwood, TN 37027

Family Chiropractic
and Wellness Center

NEW PATIENT INFORMATION

Please complete ALL questions below unless otherwise indicated.

First Name *Last Name* *Date*

Street Address *City* *State* *Zip*

Cell Phone Provider *Cell Phone* *E-Mail Address*

Employer *Occupation*

Birth Date *Age* *Social Security #* *Marital Status (circle)* M D S W

Spouse's Name *Employer* *Birth Date*

Children's Name and Ages: ______

*Who may we thank for referring you?*______

*Name of Insurance Company (if applicable)*______

Is your visit the result of an auto or work injury? *Yes* *No*

Have you had chiropractic care in the past? Yes No If yes, how long ago?______

What condition took you to the chiropractor?______

Who was your previous chiropractor?______

When was your last adjustment?______

HIPAA
Privacy Review
Initials:______

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PATIENT HISTORY

Please complete ALL questions below.

LIST ANY SURGERIES:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Wrist ☐ Shoulder

☐ Other: ____________ Please Describe: ____________

LIST ALL PAST MEDICAL HISTORY CONDITIONS:

☐ Broken Bones ☐ HIV ☐ Arthritis ☐ Cancer ☐ Chest Pain ☐ Minor Heart Problem

☐ Depression ☐ Diabetes ☐ Dizziness ☐ Epilepsy ☐ Parkinson's ☐ Neurological Problems

☐ Fainting ☐ Fatigue ☐ Multiple Sclerosis ☐ Pacemaker ☐ Genetic Spinal Condition

☐ Headaches ☐ Hepatitis ☐ High Blood Pressure ☐ Prostate Problems ☐ Spinal Cord Injury

☐ Significant Weight Change ☐ Menstrual Problems ☐ Stroke/Heart Attack

☐ Other: ____________

LIST ANY MEDICATIONS YOU ARE TAKING:

☐ Anxiety ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin ☐ Birth control ☐ Cardiovascular ☐ Allergy ☐ Seizure

☐ Other: ____________

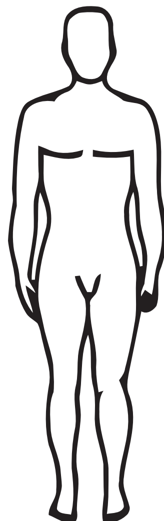
LIST YOUR FAMILY HISTORY:

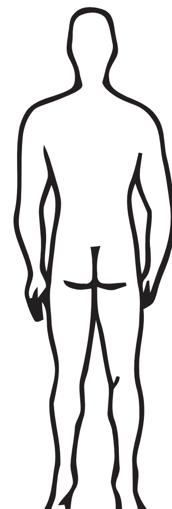
☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition

☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio

☐ Prostate Problems ☐ Stroke/Heart Attack

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW





What is your major complaint? ____________________ ***Date Problem Began:***__________

Is this the result of an auto or work injury? *Yes* *No*

*How did this problem begin (falling, lifting, etc.)?*____________________

*List other doctors you have seen for this condition:*____________________

Do you have any family members with the same condition? *Yes* *No* *If yes, who?*__________

How is your condition changing? *getting better* *getting worse* *not changing*

Have you had this condition in the past? *Yes* *No*

Please rate your pain on a scale of 0 to 10 (0 = no pain, and 10 = excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving? (0=no effect, and 10=no possible activities)

0 1 2 3 4 5 6 7 8 9 10

Describe the nature of your symptoms:

Dull *Sharp* *Numb* *Burning* *Shooting* *Tingling* *Radiating Pain*

Tightness *Stabbing* *Throbbing* *Other:*____________________

*What activities aggrevate your condition?*____________________

*What makes your pain better?*____________________

How often do you experience your symptoms throughout the day?

Constantly (76-100%) *Frequently (51-75%)* *Occasionally (26-50%)* *Intermittently (0-25%)*

Do you have a secondary complaint?____________________***Date Problem Began:***__________

Please rate your pain on a scale of 0 to 10 (0 = no pain, and 10 = excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving? (0=no effect, and 10=no possible activities)

0 1 2 3 4 5 6 7 8 9 10

Describe the nature of your symptoms:

Dull Sharp Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other:____________________

What actitives aggrevate your condition?____________________

What makes your pain better?____________________

How often do you experience your symptoms throughout the day?

Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

Any Additional complaints?____________________

____

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 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, resulting in a lessening of the body's innate ability to express 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 subluxations.

CONSENT FOR TREATMENT
I, the undersigned, a patient in this office hereby authorize Dr. Jennifer Bett, Dr. Saira Kay (and whomever they may designate as their assistant(s)) to administer treatment as is necessary. I also certify that no guarantee or assurances have been made to me as to the results that may be obtained. I understand and agree that health and accident insurance policies are an agreement between the insurance company and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from any insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

____

Signature ***Date*** ***Witness Signature***

Women Only

Is there any chance you are pregnant? Yes No If yes, how many weeks?________________________

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and that Dr. Bett-Gray and Dr. Kay have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period:___________________________________

The above information is true and accurate to the best of my knowledge.

____

Patient Signature ***Date*** ***Witness***

____

Parent or Guardian Signature ***Date*** ***Witness***

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

THE NATURE OF CHIROPRACTIC TREATMENT: The doctor will use her hand or a mechanical device in order to move your joints. You may hear a noise and/or feel movement in your joint during an adjustment. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, or intersegmental traction may also be used.

Initials:______

POSSIBLE RISKS: As with any health care procedure, complications are possible following a chiropractic adjustment. Com-plications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns, or minor complications.

Initials:______

PROBABILITY OF RISKS OCCURRING: The risks of complications due to chiropractic treatment have been described as "rare". The risk of cerebrovascular injury or stroke, has been estimated at one in a one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Initials:______

RISKS OF REMAINING UNTREATED: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Initials:______

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Printed Name	***Signature***	***Date***
Parent or Guardian Signature	***Witness Signature***	***Date***