HEALTHY FOUNDATIONS
SPINAL CARE

Personal Info:

Full Name:_____Preferred Name:_____

Gender: Male☐ Female☐ Height_____ Weight_____

Date of Birth ___/___/_____ Email:_____

Phone number :(___)_____ (___)_____ (___)_____
Check Preferred: Home☐ Work☐ Cell☐

Address_____City_____State _____ Zip _____

Occupation/Employer:_____

Relationship Status:_____Name of spouse/significant other_____

Do You Have Children? **Yes**☐ **No**☐ If Yes, How Many and What Ages?_____

_____

Emergency Contact:

Name:_____Phone: (___)_____

Relationship:_____

Background:

What is the primary reason for your visit?_____

_____

Have you sought care from another provider for this issue? **Yes**☐ **No**☐ Who?_____

Have you had diagnostic procedures performed for this issue? **Yes** ☐**No**☐

If yes, what procedure, when was it performed and what was the Diagnosis?

_____

How did you hear about us?_____

Have you been to a chiropractor before? **Yes** ☐**No**☐, Who?_____ When?_____

Was it a good experience? **Yes** ☐**No**☐ Are you apprehensive of Chiropractic Care? **Yes** ☐**No**☐

If yes, Why?_____

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General Health Survey

Would you consider yourself: ☐ Easily Stressed ☐ Difficult to Stress

How often do you feel that you are in a "stressed out" state? ☐Rarely ☐Sometimes ☐Frequently

What most commonly causes you to become "stressed?"_____

How many hours of sleep you get per night? ____ Do you wake up throughout the night? Y☐N☐

How do you most commonly wake up? ☐Tired ☐Refreshed

Is it typical for you to feel fatigued throughout the day? Y☐N☐

Do you "need" a cup of coffee/stimulant in order to get through an afternoon? Y☐N☐

Do you drink alcohol Y☐N☐ How many drinks per week?_____

Do you drink sugary drinks (Sodas, Sweet tea, Processed juices, Energy Drinks)? Y☐N☐

- How many drinks per week?_____

Do you smoke cigarettes? Y☐N☐ How many packs per week?_____

Please list any drugs that you are currently taking (over the counter, prescription, recreational):

_____

_____

Please list any vitamins or supplements that you are currently taking:_____

_____

How often per week do you engage in physical activity (heart rate raised for at least 15 consecutive mins)? _____

How many servings of fruit/vegetables do you eat on an average day?_____

Have you had any recent injuries (within the past year)?_____

_____

Do you have current issues resulting from a prior injury/accident?_____

_____

Please list your surgical history: _____

_____

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Please mark any of these symptoms that you have noticed within the last 6 months

Poor Balance ☐	Jaw Pain ☐	High/low blood sugar ☐
Lack of Coordination ☐	Chest pain ☐	Upset stomach ☐
Speech impediment ☐	Heart Palpitations ☐	Gassy/Bloated ☐
Vision Changes ☐	Shortness of breath ☐	Heartburn ☐
Difficulty Hearing ☐	Racing Heart ☐	Constipation ☐
Ringing Ears ☐	Thyroid problems ☐	Diarrhea ☐
Loss of Muscle Strength ☐	High/Low blood pressure ☐	Incontinence ☐
Decreased Range of Motion ☐	Difficulty sleeping ☐	Allergies ☐
Poor Posture ☐	Fatigue ☐	Itchy skin/Eyes ☐
Muscle Atrophy (shrinking) ☐	Anxiety ☐	Sinus Infections ☐
Muscle cramping ☐	Irritability ☐	Skin Infections ☐
Muscle Tension ☐	Brain Fog ☐	Rashes ☐
Numbness/tingling ☐	Discoloration of Extremities ☐	Frequently "Sick" ☐
Joint Pain ☐	Cold hands/feet ☐	Ear infections ☐
Joint crepitus ☐	Varicose Veins (spider Veins) ☐	Headaches ☐
(grating with movement)	Swelling ☐	Fertility Problems ☐
Arthritis ☐	Easy Bruising ☐	Urinary Tract infections ☐

Please note, this list is not exclusive. If you have any other symptoms or health conditions not listed please write them below. _____

_____

_____

_____

_____

For Females Only:

When was the first day of your last period?_____ Are your periods regular (28-32 day cycle)? Y☐N☐

Are you pregnant? Y☐N☐ Have you had difficulty becoming pregnant? Y☐N☐

Number of pregnancies:_____ Did you carry full term? Y☐N☐

Are you currently using hormone regulating contraceptives? What type/brand? Y☐N☐ _____

Do you suffer from PMS? Y☐N☐ Have you had Uterine Fibroids? Y☐N☐

Have you reached menopause? Y☐N☐

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any healthcare procedure, there are certain complications which may arise during chiropractic care. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strain, separations and burns. Some types of manipulations have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients will feel stiffness or soreness in the first few days of treatment. The Doctor will make every effort to screen for any possible contraindications to care; however if you have a condition that would not otherwise come to the Doctor's attention it is your responsibility to inform the Doctor.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. Stroke and/or arterial dissection cause by chiropractic manipulation of the neck has been subject to ongoing research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk for arterial stroke.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

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.

Consent to Treatment (Minor)

I hereby request and authorize Roy Farris, DC of Healthy Foundations Spinal Care, LLC to perform diagnostic adjustments and other treatment to my minor son/daughter: _____.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As Of this date, I have legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and condition of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or any other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

I have read or had read to me 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.

Patient:

_____	_____	_____
Printed Name	**Signature**	**Date**

Parent/Guardian (If a Minor):

_____	_____	_____
Printed Name	**Signature**	**Date**

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Privacy Notice and Agreement

At Healthy Foundations Spinal Care we respect your privacy. The purpose of this form is to allow you to extend or deny permission for the use of your personal information, as described below.

Y☐ N☐	I give Healthy Foundations Spinal Care permission to call me by name in the office and on the telephone.
Y☐ N☐	I give Healthy Foundations Spinal Care permission to call and remind me of upcoming appointments or to reschedule my appointments.
Y☐ N☐	I give Healthy Foundations Spinal Care permission to send things to me by mail occasionally, such as, cards for special occasions, special promotions, etc.
Y☐ N☐	If I provide my email address to Healthy Foundations Spinal Care, I give Healthy Foundations Spinal Care permission to email me such things as newsletters, talk dates, clinic closings, research, etc.
Y☐ N☐	If I fill out a testimonial form or write a letter of that nature, I give Healthy Foundations Spinal Care permission to use that information in whatever way they see fit (example: on their website.)

I have read and fully understand the above information provided above. I have given my permission and/or made my objections clear.

Patient's Name (print):_____

Patient's/Guardian's Signature:_____

Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Healthy Foundations Spinal Care Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Healthy Foundations Spinal Care and how I may obtain access to and control this information.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Date