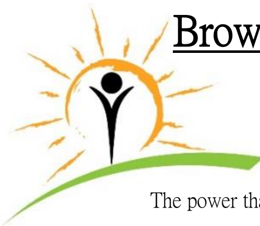


Brown Family Chiropractic Center

235 St. John Rd Suite 40 Fletcher, NC 28732
tel: 828-681-5454 WWW.GR8SPINE.COM
fax: 828-681-5054 email: drjon@gr8spine.com

The power that made the body heals the body

This Is All About You...

Name_______________________________________ (MI) _____ Home # __________________ Cell #___________________
Street Address____ City ___________________State_____ Zip Code_________
Birth-date ____/____/____ Age _____ E-mail Address (Never Sold) ____
Would you like to receive a FREE E-mail Health Newsletter from Dr. Brown? ☐ YES ☐ NO

A caring family member or friend normally refers practice members to our office. What made you decide to visit our office?
Family/Friend Name: _____________________ OR ☐ Google ☐ Telephone Call ☐ Website ☐ Office Sign ☐ Other:____________
May we use your name and/or picture for our referral board? ☐ YES ☐ NO

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Widow ☐ Married- Spouse's Name ______________________
Children: ☐ YES ☐ NO Name ___________________age_____ / Name ___________________ age____
Name ___________________age_____ / Name ___________________ age____

Employment ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Not Employed ☐ Student
Current Occupation ____ Employer _____________________________________
Work # __________________ Employment Mailing Address ____

- What activities do you do at during the day: ***(Check all that apply)***

-Sit:	☐ Most of the day	☐ Half the day	☐ A little of the day
-**Stand:**	☐ Most of the day	☐ Half the day	☐ A little of the day
-**Computer work:**	☐ Most of the day	☐ Half the day	☐ A little of the day
-**On the phone:**	☐ Most of the day	☐ Half of the day	☐ A little of the day
-**Driving:**	☐ Most of the day	☐ Half of the day	☐ A little of the day
-**Misc.**	☐ Perform manual labor	☐ Reads a lot	☐ Travels Frequently

- What activities and hobbies do you enjoy? ____

Previous Chiropractic Care

1. Have you ever been to a chiropractor before? ☐ YES ☐ NO If yes, date of last adjustment ________________
2. Previous chiropractor's name/location: _________________________________
3. When was your last complete spinal examination, including x-rays? _______________________
4. Spinal Misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your neck, back or other body parts? ☐ YES ☐ NO If yes, where? __________________________________
5. Have you ever been told that you have a spinal curvature, spinal arthritis **or** inherited spinal problem? ☐ YES ☐ NO
6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
   POOR – 1- 2- 3- 4- 5- 6- 7- 8- 9- 10- EXCELLENT
7. Stress can cause or accelerate spinal damage. How would you rate your level of stress within the last 90 days?
   LOW- 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – HIGH
8. Have you ever heard of the term "subluxation"? ☐ YES ☐ NO If yes, what is it? ___________________________

Chief Complaint(s). Briefly describe your symptoms/pain below:
1) ____ For how long? ___________
2) ____ For how long? ___________
3) ____ For how long? ___________

9. How often do you experience these symptoms? (check) ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently
10. How are your symptoms changing with time? ☐ Getting Worse ☐ Staying the Same ☐ Getting Better
11. Using a scale from 0-10 (10 being the worst), how would you rate your problem (s)? *(please circle)*
    0 1 2 3 4 5 6 7 8 9 10
12. How much has the problem interfered with your work? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Substantially ☐ Extremely
13. Has the problem interfered with your social activities? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Substantially ☐ Extremely
14. Who else have you seen for your problem? ☐ No one ☐ Chiropractor ☐ Neurologist ☐ ER physician
    ☐ Primary Care Physician name: ______________ ☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist
15. How do you think your problem(s) began? ____
16. Do you consider this problem to be severe? ☐ YES ☐ Yes, at times ☐ NO
17. What aggravates your problem? ☐ Always there OR ____________________________________
18. What helps alleviate the pain? ____
19. What concerns you the most about your problem? ______________________________________
20. How would you rate your overall Health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
21. What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None
22. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past.
    If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss	☐	☐ Dizziness
☐	☐ Asthma	☐	☐ Visual Disturbances	☐	☐ Muscular Incoordination
☐	☐ Chronic Sinusitis	☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite
☐	☐ Jaw Pain	☐	☐ Abdominal Pain		
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	**For Females Only**	
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Birth Control Pills
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder	☐	☐ Hormonal Replacement
☐	☐ Cancer	☐	☐ General Fatigue	☐	☐ Pregnancy
☐	☐ Tumor	☐	☐ Other:__________________________		

23. List any falls, injuries (including broken bones and concussions), accidents and surgeries you have experienced in your lifetime (please list date)

____________________________________When? ______ ____________________________________When? ______
____________________________________When? ______ ____________________________________When? ______
____________________________________When? ______ ____________________________________When? ______

Medications:

- Prescription drugs may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. Please list and describe what prescription drugs you are taking and what they are for:

________________________________ ________________________________ ______________________________
________________________________ ________________________________ ______________________________
________________________________ ________________________________ ______________________________

- Please list all of the over-the-counter medications and/or supplements that you are currently taking:

________________________________ ________________________________ ______________________________
________________________________ ________________________________ ______________________________

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELLBEING:

- □ **I AM CONCERNED ABOUT RELIEF OF A PARTICULAR SYMPTOM.**
- □ **I AM ONLY CONCERNED ABOUT RELIEF OF A PARTICULAR SYMPTOM, AND PREVENTING ITS RETURN.**
- □ **I WANT OPTIMUM HEALTH AND WELLBEING ON EVERY LEVEL AVAILABLE TO ME.**

- Are you willing to follow the doctor's recommendations? ☐ Yes ☐ No
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. We accept check, cash, credit cards.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understanding and it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ____ Date: ___________

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 for the same objective.

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

Adjustment: The 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: The 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 mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose vertebral subluxations. 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, ____ have read and fully understand the above statements.
(print name)

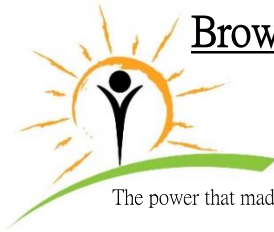
All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

____ __________
(signature) (date)

Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and 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 cycle __________

____ ___________
(signature) (date)

Witness: ____ ___________
(date)



Brown Family Chiropractic Center

235 St. John Rd Suite 40 Fletcher, NC 28732
tel: 828-681-5454 WWW.GR8SPINE.COM
fax: 828-681-5054 email: drjon@gr8spine.com

The power that made the body heals the body

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information (PHI) by Brown Family Chiropractic Center, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Brown Family Chiropractic Center, P.A. I understand that diagnosis or treatment of me by Jonathan R. Brown, D.C. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Brown Family Chiropractic Center, P.A. is not required to agree w to the restrictions that I may request. However, if Brown Family Chiropractic Center, P.A. agrees to a restriction that I request, the restriction is binding on Brown Family Chiropractic Center, P.A. and Jonathan R. Brown, D.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jonathan R. Brown, D.C. or Brown Family Chiropractic Center, P.A. has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Brown Family Chiropractic Center, P.A Notice of Privacy Practices prior to signing this document. Brown Family Chiropractic Center, P.A Notice has been made available to me at the office front desk and electronically on the website.

Brown Family Chiropractic Center, P.A. reserves the right of change the privacy practices that are described in the Notice of privacy Practices. I may obtain a revised notice of the privacy practices by calling the office and requesting a copy.

Patient or Representative Signature: ____ Date: ______________

Printed name of Patient or Representative: ____

Description of Authority/Relationship: ____