Centra
FAMILY CHIROPRACTIC

PERSONAL INFORMATION

Name (Legal) : Preferred Name:

Age: Date of Birth: Sex: M F

Address

Cell Phone: ( ) Email:

Occupation: Employer:

Name of person(s) we can discuss your care/account with (name, relationship)

Who can we thank for referring you or how did you hear about our office?

REASON FOR SEEKING CARE

What is your reason for seeking care?

When did this begin? (if applicable)

Please list ALL accidents, falls, traumas and/or surgeries you have had:

Do you have any illnesses or had any in the past?

What is this affecting that is MOST important in your life?

Have you seen any other providers for this condition? (List all that apply

Have you seen a chiropractor before? Yes No

How long ago? Clinic/Doctor's Name:

What is your reason for change? (if applicable)

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Please Explain:

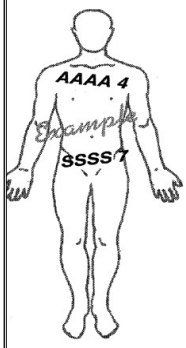
What health goal, if you were to accomplish, would have the greatest impact on your health?

Please list any medications and/or supplements you are taking:

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

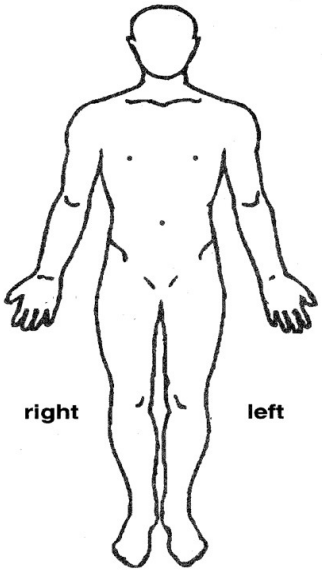
Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



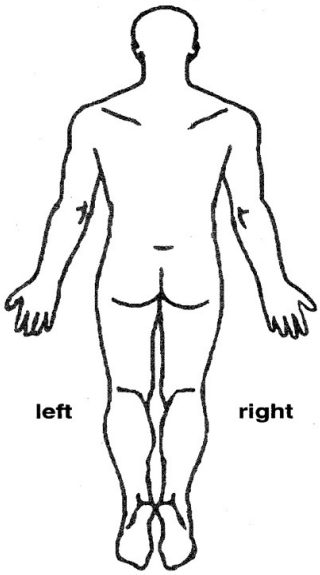
Example

Right



right left

Front



left right

Back

Left

Check any of the following symptoms in which you have now (N) or the past (P):

(N)	(P)	
___	___	Severe or frequent headaches
___	___	Sinus Infections or Frequent colds
___	___	Asthma
___	___	Allergies
___	___	Loss of sleep or weight (circle one)
___	___	Loss of Concentration
___	___	Depression
___	___	Nervousness/Anxiety
___	___	Tremors
___	___	Arthritis/Bursitis
___	___	Irritability
___	___	Dizziness
___	___	Acid Reflux/difficult digestion
___	___	Constipation
___	___	Diarrhea
___	___	Anemia
___	___	Jaundice or Liver Trouble
___	___	Gallbladder Trouble
___	___	Bed wetting
___	___	Painful or Frequent Urination
___	___	Itching or rashes
___	___	Eczema or Psoriasis

(N)	(P)	
___	___	Deafness
___	___	Earache
___	___	Eye pain
___	___	Hay Fever
___	___	High or Low Blood Pressure (Circle One)
___	___	Rapid or Slow Heartbeat (Circle One)
___	___	Stroke
___	___	Swelling Ankles
___	___	Chest Pain
___	___	Chronic Cough
___	___	Difficulty Breathing or Wheezing (Circle One)
___	___	Nausea/Vomiting

_____

FOR WOMEN ONLY:

___	___	Cramps or backache during period
___	___	Excessive flow/discharge
___	___	Hot flashes
___	___	Irregular cycle/painful menses
___	___	Miscarriage

Are you pregnant? Yes___ No

TERMS OF ACCEPTANCE AND CONSENT TO CHIROPRACTIC SERVICES

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 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 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 hereby request and consent to chiropractic adjustments and other procedures (diagnostic x-rays if necessary) by Dr. Nicholas Centra, Dr. Tara Centra and staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Centra Family Chiropractic personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Centra Family Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Centra Family Chiropractic responsible for any errors or omission that I may have made in the completion of this form.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read, or have had read to me, the full above terms of acceptant and consent to chiropractic services and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff. I have also read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature **Relationship to Patient** **Date**

X-RAY CONSENT FOR WOMEN OF CHILDBEARING AGE

X-ray of the pelvis exposes the uterus to radiation. The last ten days following onset of the menstrual cycle are generally considered safe for x–ray examination.

Date of onset of last menstrual period:_____

I am pregnant: Yes No (Circle One)

Signature: **Date:**

PERSONAL FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. And, that Centra Family Chiropractic does not take any insurance. I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In the case of a pre-pay plan, payments made for services not utilized will be returned.

Signature: **Date:**

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Facebook page or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the circle that applies to you:

- ☐ Sure! You can use my picture on the CFC website, FB page, and/or other social media posts as long as I look good!
- ☐ No thanks! I'll pass for now

Signature: **Date:**