AMERICAN FAMILY & SPORTS CHIROPRACTIC CENTER INC

Dr. Elizabeth J. Hennighan **PATIENT #:_____**

PATIENT REGISTRATION

NAME: _____ AGE: _____ DATE: _____

ADDRESS: _____
Residence and mailing City State Zip Code

HOME TELEPHONE ( ) _____ CELL ( ) _____ BIRTHDATE_____

MALE_____FEMALE_____ SOCIAL SECURITY #_____ OCCUPATION_____

EMPLOYER ADDRESS_____ PHONE # ( ) _____

NAME OF SPOUSE/PARENT _____ SPOUSE'S OCCUPATION_____

NO. OF CHILDREN_____ AGES _____ RESPONSIBLE PARTY _____

REFERRED BY_____YELLOW PAGES___BELLSOUTH___COMPLETE_____SIGN___OTHER____

REASON FOR CONSULTING OUR OFFICE_____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a **full** spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most the times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS	**YES**	**NO**	**UNSURE**
Did you have any childhood illnesses?	_	_	_
Did you have any serious falls?	_	_	_
Did you play youth sports?	_	_	_
Did you take/use any drugs?	_	_	_
Did you have any surgery?	_	_	_
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)?	_	_	_
Were you involved in any accidents? (i.e. automobile, sports, bikes)?	_	_	_

	YES	**NO**	**UNSURE**
Was there any prolonged use of medicine such as antibiotics or an inhaler?	_	_	_
Did you suffer any other traumas (physical or emotional)	_	_	_
Where you vaccinated?	_	_	_
As a child, were you under regular Chiropractic care?	_	_	_

COMMENTS:

_____

If you are accepted as a patient you are expected to pay at the end of each visit unless prior arrangements are approved. Returned checks will be subject to service fees in accordance with the Laws of the State of Florida, with a minimum charge of $25.00. There is a $25.00 fee for missed appointments without 24 hours notice of cancellation. This office will gladly prepare medical claim forms, but we cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for payment whether or not paid by insurance. Responsible Party agrees to pay for all attorney fees and collection costs necessary to collect fees and expenses.

_____ _____

Signature **Date**

Addressing the Issues That Brought You to the Office

If you have no symptoms or complaints, and are here for continuous wellness services, please check () here ____. "Wish to have Chiropractic Wellness Services" and skip to "Family Health Profile." Others need to briefly describe the chief area of complaint, including the effect it has had

_____
_____
_____
_____

If you are experiencing pain, is it…..

( ) Sharp () Dull () Comes and goes () Travels () Constant

Since the problem started, it is…. () About the same () Getting better () Getting worse

What makes it worse: _____

Yes, it interferes with: () Work () Sleep () Walking () Sitting () Hobbies () Leisure

() Other_____

Other Doctors seen for this problem (please list specialty and last visit _____

List any X-rays or MRI's taken in the past year including where_____

_____

Please check () all symptoms you have ever had, even if they do not seem related to your current problem.

( ) Headaches	( ) Pins and needles in legs	( ) Fainting	( ) Neck Pain
( ) Pins and Needles in arms	( ) Buzzing in ears	( ) Back Pain	( ) Loss of Balance
( ) Dizziness	( ) Ringing in ears	( ) Nervousness	( ) Lights bother eyes
( ) Numbness in fingers	( ) Numbness in toes	( ) Loss of taste	( ) Tension
( ) Fatigue	( ) Depression	( ) Cold Hands	( ) Cold Feet
( ) Sleeping problems	( ) Stiff Neck	( ) Menstrual Irregularity	( ) Mood Swings
( ) Menstrual Pain			

List any medications you are taking including any injections and vitamins _____

_____

Family Health Profile: At our office we are not only interested in your health and well-being, but also the health and well-being of your family illness. Please mention below any health conditions or concerns you may have about your

Children _____ **Spouse** _____

Mother _____ **Father** _____

Other _____

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I authorize the release of any medical information necessary to process the claim and request payment of insurance benefits either to myself or the party who accepts assignment below.

Signed_____Date_____

CONSENT TO TREATMENT OF MINOR

I hereby authorize Elizabeth Hennighan, D.C. and whomever she may designate as her assistants to administer treatment(s) as she so deems necessary to_____, relationship_____. Dated at Port Orange, FL., on this _____day of _____, 20_____.

Signed_____Date_____

MEDICARE WAIVER

Manual manipulation of the spine (98940-98942) is the only covered chiropractic service allowed by law to be reimbursed by Medicare. All other services rendered to the beneficiary are their financial responsibility. If Medicare determined that a particular service, although it would be otherwise covered, is not "reasonable and necessary" under Medicare program standards (12-24 manipulations per year), Medicare will deny payment for that service. Manual spinal manipulations are only covered under the Medicare program for certain conditions that Medicare deems medically reasonable and necessary.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

Signature **Date**