

My mission is to help as many people in my lifetime as I can~ especially children! Dr. John Ferguson



Confidential Health Information

Please allow our staff to photocopy your insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date: ____ / ____ / ____

Your Name: _____ Gender: Male Female
First Middle Last

Your Address: _____ Birth Date: ____ / ____ / ____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ May we contact you at work? Yes No

Cell Phone: _____ Fax: _____

Email address (for Exercises & Care Instructions, Monthly Newsletter): _____

Would you like information on a specific topic? _____

Your Occupation: _____ Your Employer: _____

Marital Status: _____ Spouse/Significant Other's Name: _____

Emergency Contact: _____ Phone: _____

Insurance Carrier: _____ Policy Number: _____

Have you consulted a Chiropractor before? Yes No When? _____ If so, whom? _____

Reason for leaving: _____

Spinal X-Rays taken in the last 12 months? YES NO Body Part(s) _____

Any other previous imaging studies (CT scan, MRI, etc.) YES NO Body Part(s) _____

Present MD/DO: _____ Address: _____

Phone: _____

Who may we thank for referring you into our office? _____

Health History

Date of last dental examination: _____

Do you exercise? Yes No

Do you smoke? Yes No

Exercise Indoor Activities: _____

Do you consume alcohol? Yes No

Exercise Outdoor Activities: _____

Rate your sleep hours per night: 4-6 6-8 8-10 12+

Do you wake rested? Yes No

Rate your diet (please circle) : Poor Fair Medium Good Excellent

What health concern(s) bring you into the office? _____

Describe your health concern(s): _____

List any traumas (falls, auto accidents, sports or work injuries): _____

Approximately what percentage of your day do you spend sitting? _____ %

Surgery/Operations (please list): _____

Surgery recommended but not performed (please list): _____

Do you take supplements? Yes No List: _____

Have you ever been knocked unconscious: Yes No Don't Know If so, for how long: _____

List any medication or drugs you are currently taking and what they are for (ie. Lipitor for high cholesterol): _____

Have you previously been hospitalized: Yes No Reasons: _____

Any family health conditions for spouse, partner, children Yes No Please list: _____

Acknowledgements:

To set clear expectations, improve communications and help you get the best results in the appropriate amount of time, please read each statement and initial agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I may be adjusted in a semi-private room where private information I offer may be overheard by others. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct spinal misalignments/nerve stress (vertebral subluxations). Chiropractic is a separate healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved parties.

Initials _____ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YY): _____

Initials _____ I grant permission to be called, texted and/or e-mailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern(s).

Signature: _____ Date: _____