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

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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?____

Habits of Lifestyle

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

Exercise Indoor Activities: ___________________________

Exercise Outdoor Activities: __________________________

Rate your sleep hours per night: ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+ Do you wake rested? ☐ Yes ☐ No

Rate your appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Rate your diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner

Do you eat per day: ☐ 1 meal ☐ 2 meals ☐ 3 meals ☐ 4 meals ☐ More than 4 meals

How much water do you drink/day?__________________ Soda?_____________ Coffee?____________

Date of last dental examination: ____

Falls (please list any major or minor falls in your life, i.e. slipping on ice, sports, work related):_________________

____

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

Surgery/Operations (please list):____

Surgery recommended but not performed (please list):____

Do you take vitamins and minerals? ☐ 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: ☐ 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:_____________________