Welcome to Homegrown!

Please fill out our Health Record as completely and accurately as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.
It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About this Patient

First Name _____ **Last Name** _____

Street Address _____

Birthday _____ **Social Security #** _____

City _____ **State/Province** _____ **Zip Code** _____

Phone _____ **Cell Phone** _____

Email _____ **Gender**

◯ Male ◯ Female ◯ Other

Marital Status

◯ Married ◯ Single

About the Spouse

First Name _____ **Last Name** _____

Spouse's Cell Phone _____

Employer Information

Employer _____

Work Address _____

Work City _____ **Work State** _____ **Work Zip** _____

Work Phone

Type of Work

Reason for this Visit

Is the purpose of this appointment related to:

◯ Job Related ◯ Sports ◯ Auto Accident
◯ Fall ◯ Chronic Discomfort ◯ Other

Please explain.

When did this condition begin?

Has this condition

◯ Gotten worse ◯ Stayed Constant ◯ Comes and goes

Has this condition occurred before?

◯ Yes ◯ No

Explain

Have you seen other doctors for this condition?

◯ No ◯ Yes

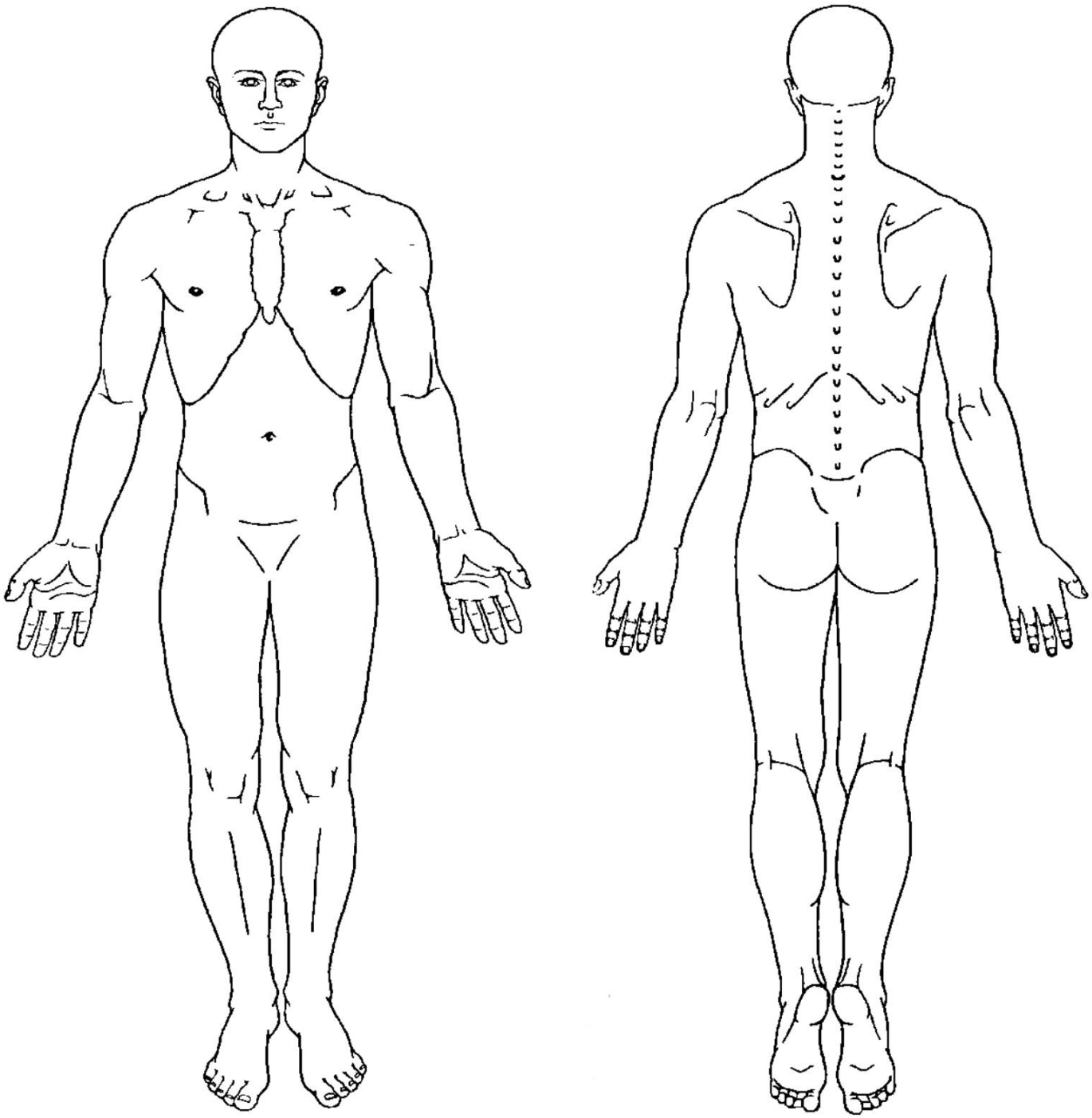
Doctor's Name (s)

Type of Treatment

Results

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Does your problem interfere with:

- ☐ Sleeping
- ☐ Driving
- ☐ Bending
- ☐ Lifting
- ☐ Social Life
- ☐ Sitting
- ☐ Standing

Experience with Chiropractic

How did you hear about our office?

_____

Have you been adjusted by a chiropractor before?

- ◯ Yes
- ◯ No

Reason for those visits?

Doctor's Name

Approximate date of last visit?

Has any adult in your family seen a Chiropractor?

◯ Yes ◯ No

Has any child in your family seen a Chiropractor?

◯ Yes ◯ No

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort

☐ Yes

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

☐ Yes

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

☐ Yes

Patient's Signature

Date

Medications I Now Take:

☐ Nerve Pills
☐ Blood Pressure Medicine
☐ Blood Thinners
☐ Other
☐ Pain Killers (including Aspirins)
☐ Insulin
☐ Tranquilizers
☐ N/A
☐ Muscle Relaxers
☐ Stimulants
☐ Cannabis

Please list any medications you are currently taking

Health Habits

Do you smoke?

◯ Yes ◯ No

Do you drink alcohol?

◯ Yes ◯ No

Do you drink coffee?

◯ Yes ◯ No

Do you exercise regularly?

◯ Daily ◯ Moderately ◯ No

Do you wear:

☐ Heel lifts
☐ Inner Soles
☐ Sole Lifts
☐ Arch Supports

Health Conditions

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Health Conditions:

- ☐ Severe or Frequent Headaches
- ☐ Sinus Problems
- ☐ Dizziness
- ☐ Cancer
- ☐ Loss of Sleep
- ☐ Hepatitis
- ☐ Pain Between the Shoulders
- ☐ Frequent Neck Pain
- ☐ Numbness or Pain in Arms/Legs/Hands
- ☐ Lower Back Problems
- ☐ Digestive Problems
- ☐ Ulcers/Colitis
- ☐ Heart Attack/Stroke
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Congenital Heart Detect
- ☐ Heart Surgery/Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Arthritis
- ☐ Alcohol/Drug Abuse
- ☐ Venereal Disease
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Shingles
- ☐ Chemotherapy
- ☐ Anemia
- ☐ N/A

Family Medical History:

- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart disease
- ☐ Other
- ☐ N/A

Please explain

_____

Please list any surgeries you have had:

_____

FOR WOMEN ONLY:

Are you pregnant?

◯ Yes ◯ No

Are you nursing?

◯ Yes ◯ No

Are you taking birth control?

◯ Yes ◯ No

Do you experience painful periods?

◯ Yes ◯ No

Do you have irregular cycles?

☐ Yes ☐ No

Do you have breast implants?

◯ Yes ◯ No

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Patient's Signature **Date**

_____ _____

Guardian or Spouse's Signature **Date**

_____ _____

Who should receive bills for payment on your account?

- ☐ Patient
- ☐ Spouse
- ☐ Parent

X-Ray Policy

It is understood and agreed that if the Doctor finds it medically necessary to take x-rays that these images will be sent to Littrell Radiology for x-ray reading/report purposes. The radiology overread fee is $25.00 per set.

Patient's Signature _____ **Date** _____

Emergency Contact

First Name _____ **Last Name** _____

Relationship

_____

Work Phone _____ **Home Phone** _____

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself . I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company

_____

Policy # _____ **Group #** _____

Address

_____

Phone Number

_____

ABOUT THE INSURED PERSON

First Name _____ **Last Name** _____

Social Security # _____ **Date of Birth** _____ **Relation** _____

Nutrition and self-care are just two of the components in obtaining optimal wellness.

Please let us know what you are currently doing for your health.

Things I do currently to support my health include:

- ☐ Drink plenty of water
- ☐ Pray/Meditate
- ☐ Maintain positive attitude
- ☐ Maintain the proper weight
- ☐ Use a cervical pillow
- ☐ Exercise regularly
- ☐ Yoga/Pilates/Aerobics
- ☐ Self-improvement books
- ☐ Receive regular massages
- ☐ Attend religious services
- ☐ Get plenty of rest
- ☐ Alcohol in moderation
- ☐ Eat organically grown foods
- ☐ Counseling/Therapy
- ☐ Annual physical examinations
- ☐ Acupuncture
- ☐ Homeopathic remedies
- ☐ Vitamins, minerals or herbs
- ☐ Orthotics/Heel Lefts

Please indicate which of these you do/have on a consistent basis:

- ☐ Eat fast food
- ☐ Feel overwhelmed/Exhausted/Fatigued
- ☐ Experience food sensitivities/Allergies
- ☐ History of pinched nerve/Slipped or herniated disc/Joint degeneration
- ☐ Family diagnosed with Osteoporosis/Thin brittle bones
- ☐ Anxiety/Nervousness
- ☐ Tooth decay
- ☐ Low energy/Loss of vitality
- ☐ Poor gum health/Gingivitis
- ☐ Struggle with weight loss
- ☐ High cholesterol
- ☐ Currently taking vitamin supplements
- ☐ Work long hours
- ☐ Experience gas/Bloating/Indigestion
- ☐ Periods of constipation/Loose stools/Irregularities
- ☐ Popping/Crackling/Stiffness in your joints
- ☐ Muscle cramps (sports or menstrual)
- ☐ Weak or thin/Hair/Nails/Skin
- ☐ Family history of heart disease
- ☐ Family history of colds/Flus/Infections/Poor immune system
- ☐ Cravings for sugary foods
- ☐ Lack of protein in diet
- ☐ Struggle with eating healthy throughout the day

Please list any vitamins and/or supplements you are currently taking

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Initial Consultation Form

First Name _____ **Last Name** _____

Primary Complaint (s):

Overall frequency of complaint (choose one)

◯ Constant - 100% of the time ◯ Frequent - 75% ◯ Intermittent - 50% ◯ Occasional - 25%

Overall intensity of complaint (choose one)

◯ Minimal (An annoyance but has no effect on activity)
◯ Slight (Tolerable with some impairment to activity)
◯ Moderate (Tolerable with marked impairment of activity)
◯ Severe (Intolerable and cannot perform any activities)

Is this problem affecting any other area of your body? If yes, please explain:

Does it interfere with your normal daily activities (Family, recreation, sports)?

Does your symptoms increase while performing your normal work duties?

◯ Yes ◯ No

If yes, please select the amount below that you feel your symptoms increase at work:

◯ 0% ◯ 10% ◯ 20% ◯ 30%
◯ 40% ◯ 50% ◯ 60% ◯ 70%
◯ 80% ◯ 90% ◯ 100%

What aggravates the problem?

What relives the problem?

If this problem went without being taken care of, how do you think it would affect you?

Patient's Signature **Date**

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment with our chiropractic assistants. We would prefer the make up appointment to be within the same week.
- In the instance of a no show without 24 hour notice, by phone or text, we reserve the right to charge you a $35.00 fee and we require a credit/debit card (not HSA) be kept on file.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Patient's Signature **Date**

Insurance:

We will verify all insurances and your benefits per your agreement with your carrier. After verification the Doctor will give his recommendations and an appropriate plan will be designed for each individual. Please let the front-desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Signature

Date Signed

_____

Printed Name

_____

Email

_____