CONFIDENTIAL PATIENT HEALTH RECORD

Today's Date: _____ Email Address: _____

Name: _____Middle: _____ Last: _____

Social Security Number:_____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Date of Birth (M/D/Y): _____ Sex: **M F** Marital Status: **S M W D DP LS**

[ ] Yes, you may contact me via email and text message.

Your Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Name of Significant Other: _____ Significant Other Date of Birth: _____

Number of Children: ____ Names of Children and Ages: _____

Name of Family Doctor: _____ Doctor Phone: _____

Whom may we thank for referring you to our office? _____

Have you ever received chiropractic care? **Yes No** Date of last visit: _____

Chiropractor: _____ Is this a Worker's Compensation case? **Yes No**

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

CURRENT HEALTH CONDITION:

Describe the major complaint(s)/reason(s) that bring you to our office: _____

_____

_____

When did this start? _____ Have you had this before? **Y N**

What do you feel caused this problem? _____

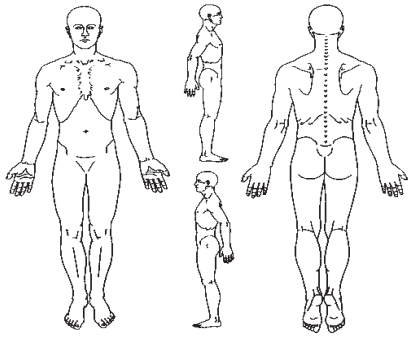
Type: **Pain Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling Weakness**

Quality: **Sharp Dull Aching Throbbing Crushing Stabbing Local Radiating Burning**

Migraine Tension Hormonal Sinus Organic

On a scale of 1-10 circle the number that represents the severity of your pain:	
NO PAIN	**0**
MILD PAIN	**1 2 3**
MODERATE PAIN	**4 5 6**
SEVERE PAIN	**7 8 9**
DISABLING PAIN	**10**

Indicate where your pain is located with an "X":



Is the Pain: **Constant Frequent Intermittent Occasional Infrequent**

What activities make your condition/pain better? _____

Is this condition worse during certain times of the day? **Yes No** When? **AM PM NIGHT**

Is this condition getting progressively worse? **Yes No**

Have you seen anyone else for this? **Yes No** Who? _____

Explain previous and current care for this problem: _____

_____

Are you taking any medications for this problem? __YES __NO Which ones?: _____

_____

Do you take any nutritional supplements? __YES __NO Which ones?: _____

_____

Do you have any allergies? __YES __NO If yes, please list here?: _____

_____

What are your short term and long term health goals?_____

_____

DAILY ACTIVITIES:

Bending	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Carrying	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Climbing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Concentrating	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Dancing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Doing Chores	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Doing Computer Work	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform

Dressing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Driving	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Gardening	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Lifting	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Performing Sexual Activity	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Playing Sports	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Pushing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Reading	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Recreating	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Rolling Over	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Running	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Shoveling	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sitting	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sitting to Stand	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sleeping	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Standing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Walking	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Watching TV	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Working	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform

Please list drugs that you currently take: _____

_____

FAMILY HEALTH HISTORY:

Does any member of your family suffer from your current condition? **Yes No** Whom? _____

Any other pertinent family history/conditions: _____

Is there a family history of: **Heart Disease Cancer Arthritis Diabetes Other:**_____

HEALTH SURVEY:

For the following conditions, please circle O for previously had or **Δ** for currently have…

Cardiovascular

O Δ Bleeding Disorders
O Δ High Blood Pressure
O Δ Low Blood Pressure
O Δ High Cholesterol
O Δ Irregular Heart Beat
O Δ Pain/Pressure in Chest
O Δ Short Breath with Exertion
O Δ Prolapsed Valve
O Δ Stroke
O Δ Heart Attack
O Δ Heart Disease
O Δ Pacemaker

Eyes, Ears, Nose, Throat

O Δ Dental Problems
O Δ Difficult Breathing
O Δ Difficult Speech
O Δ Glaucoma
O Δ Head Injuries
O Δ Loss of Balance
O Δ Ringing in Ears
O Δ Vision Problems
O Δ Hearing Loss
O Δ Eyes Sensitive to Light
O Δ Loss of Taste
O Δ Loss of Memory
O Δ Nose Bleeds
O Δ Ear Pain
O Δ Cataracts
O Δ Tonsillitis
O Δ Dizziness
O Δ Loss of Smell

Immune

O Δ Catch Colds Easily
O Δ Sinus Troubles
O Δ Frequent Influenza
O Δ Mononucleosis
O Δ AIDS/HIV
O Δ Allergies

Respiratory

O Δ Chronic Cough
O Δ Asthma
O Δ Coughing Blood
O Δ Bronchitis
O Δ Pneumonia
O Δ Emphysema

Gastrointestinal

O Δ Mucous in Stool
O Δ Liver Disease
O Δ Burping, Bloating
O Δ Colitis
O Δ Constipation
O Δ Diarrhea
O Δ Celiac Disease
O Δ Gallbladder Problems
O Δ Pain in Stomach
O Δ Hernia
O Δ Reflux
O Δ Anorexia/Bulimia
O Δ Blood in Stool
O Δ Nausea
O Δ Heartburn
O Δ Weight Gain
O Δ Weight Loss
O Δ Vomiting

General

O Δ Rheumatoid Arthritis
O Δ Anemia
O Δ Cancer
O Δ Parkinson's
O Δ Depression
O Δ Diabetes
O Δ Epilepsy
O Δ Sleeping Problems
O Δ Appendicitis
O Δ Gout
O Δ Migraines
O Δ Psychiatric Care
O Δ Hypoglycemia
O Δ Multiple Sclerosis
O Δ Thyroid Problems
O Δ Tuberculosis
O Δ Prosthesis
O Δ Joint Replacement
O Δ Rheumatic Fever
O Δ Suicide Attempt
O Δ Chemical Dependency
O Δ Tumors, Growths
O Δ Rheumatic Fever
O Δ Fainting
O Δ Skin Problems
O Δ Irritability
O Δ Nervousness
O Δ Ulcers
O Δ Polio
O Δ Arthritis
O Δ Dislocations
O Δ Broken Bones
O Δ Hepatitis
O Δ Osteoporosis

Urinary

O Δ Blood in Urine
O Δ Kidney Stones
O Δ Inability to Control
O Δ Kidney Disease
O Δ Painful Urination
O Δ Bed Wetting

Neuromuscular Skeletal

O Δ Headaches
O Δ Tingling in Hands/Feet
O Δ Herniated Disc
O Δ Numbness in Fingers/Toes
O Δ Neck Pain
O Δ Pain in Leg(s)
O Δ Pinched Nerves
O Δ Tension
O Δ Low Back Pain
O Δ Pain in Arm(s)
O Δ Stiff Neck

TO BE COMPLETED BY WOMEN ONLY

O Δ Excessive Flow
O Δ Headaches with Periods
O Δ Hot Flashes
O Δ Premenstrual Depression
O Δ Irregular Periods
O Δ Lumps in Breasts
O Δ Menstrual Cramps
O Δ Miscarriage
O Δ Painful Breasts
O Δ Vaginal Discharge
O Δ Hysterectomy
O Δ Vaginal Infections

TO BE COMPLETED BY MEN ONLY

O Δ Burning Urination
O Δ Difficulty Starting Flow
O Δ Dripping After Urination
O Δ Feeling of Incomplete Evacuation
O Δ Frequent Urination at Night
O Δ Prostate Problems

Patient Signature: _____ **Date:** _____

Examiner Signature: _____ **Date:**_____

PAYMENT INFORMATION RECORD

Patient Name: _____

Date of Birth (M/D/Y): _____

Please check one:

[ ] Yes, I have insurance that I would like verified. I am providing Fortify Chiropractic with my insurance information.

[ ] No, I do not have any insurance that I would like verified.

Subscriber's First Name: _____ Last Name: _____

Subscriber's Date of Birth (M/D/Y): _____

Subscriber's Employer: _____Occupation: _____

Work Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone: _____

Insurance Co: _____ Phone Number: _____

Address: _____

Group Number: _____ Policy Number: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Secondary Insurance Co: _____ Phone Number: _____
Address: _____

Group Number: _____ Policy Number: _____

Who is responsible for this account? _____ Relationship to Patient: _____

AUTHORIZATION TO RELEASE BENEFITS

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition an treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

AUTHORIZATION TO PAY DOCTOR/CLINIC

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor/ clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photostatic copy of this agreement shall serve as the original.

SIGNATURE_____DATE_____

Authorization to Pay
Release Authorization
is granted to

Physician Tax ID

FORTIFY CHIROPRACTIC
Dr. Anthony Dabbs
460 Main St. W.
Rainsville, AL 35986

FORTIFY
CHIROPRACTIC

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CHIROPRACTIC

CHIROPRACTIC SUPPLEMENTS WAIVER

I understand that nutritional supplements are not approved by the Food and Drug Administration (FDA). I also understand that use of nutritional supplement is not meant to diagnose, treat, cure, or prevent any disease or medical condition, and that I should consult with my physician prior to starting ANY exercise or nutritional supplement program. I additionally understand that I should also consult with my physician regarding any potential adverse interactions between medication I am currently taking and nutritional supplements before taking any such supplements. If I have, or suspect that I have, a medical problem, I will consult with my physician for diagnosis or treatment.

I hereby consent to, and assume the risks associated with, the use and consumption of nutritional supplements sold to me by FORTIFY CHIROPRACTIC and agree to follow the recommendations and instructions of my physician or chiropractor. I agree to carefully read all product packaging and labels, and I understand that if I experience any adverse side effects for allergic reactions, I should immediately stop consuming the nutritional supplement and I should immediately consult my physician. You hereby agree to fully release and discharge FORTIFY CHIROPRACTIC and all its agents, partners, directors, employees, attorney, successors, assigns and insurers of FORTIFY CHIROPRACTIC, and each of them, from all actions, causes of actions, claims, judgments, obligations, damages, and liabilities, of whatsoever kind and character, occurring at any time or prior to the date hereof, including, but not limited to, any such claims arising out of or relating to your use of nutritional supplements, including any contract, tort and any federal and state statutory claims.

I acknowledge that I have read this release carefully and understand its implications. In addition, I acknowledge that I am signing this release voluntarily. I further acknowledge that the execution of this release is a free act and deed and indicates voluntary acceptance of all the terms set forth.

Accepted and agreed to with the intent to be legally bound:

Printed Name	Signature
	Date

FORTIFY
CHIROPRACTIC

APPPOINTMENT CANCELLATION POLICY

If, for any reason, you are unable to keep an appointment we require that you telephone immediately to reschedule your visit. Charges may be applied for missed appointments or those cancelled without 24 hours notice.

We charge $50 for the first missed appointment without adequate notice of cancellation. Subsequent appointment times that are missed are subject to a $100 charge. Charges are at the discretion of the manager.

This policy was implemented out of respect for both our doctors and our patients. Late cancellations are difficult to fill. When you cancel the day of your appointment, you prevent someone else from being able to schedule and be served.

We sincerely attempt to honor all appointments at the scheduled time. If you are late, your time may need to be cut short. The best health services are based on a friendly, mutual understanding between provider and patient. We invite you to discuss with us any questions regarding our policies and services.

_____ _____

Signature Date

_____

Patient Name

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic at Fortify Chiropractic or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor at Fortify Chiropractic, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic at Fortify Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other mealth modalties, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issues. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surger. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatent options.

I have read, or have had read to me, the above concent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend for this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient or Guardian:_____

Date:_____

Printed Name of Guardian and Relationship:_____