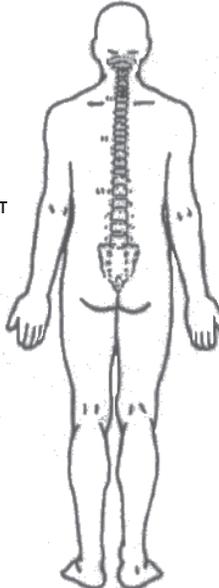


**F.L.C.C CONFIDENTIAL CASE HISTORY**

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Home address: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Sex:  M  F Marital Status:  S  M  D  W Social Security Number: \_\_\_\_\_  
 Race:  White  African-American  Hispanic  Asian  Other: \_\_\_\_\_  
 Ethnicity:  Not Hispanic or Latino  Hispanic or Latino Preferred Language: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Name of spouse (or responsible party if patient is a dependent child): \_\_\_\_\_  
 Spouse's (responsible party's) birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employer's address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Referred by: \_\_\_\_\_ Past Chiropractic Care:  Yes  No When? \_\_\_\_\_  
 Doctor's name: \_\_\_\_\_ Results: \_\_\_\_\_  
 Chief complaint(s): 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

Insurance Companies: \_\_\_\_\_  
 Are your present injuries due to an injury?  No  Yes  On the job  Auto accident  Personal injury  Other  
 Have you made a report of your accident?  No  Yes  To employer  Auto carrier  Other: \_\_\_\_\_  
 Has this accident been reported?  No  Yes  Worker's Comp.  Auto carrier  Other: \_\_\_\_\_  
 Are you now or have you ever been disabled? (Service work)  No  Yes When? \_\_\_\_\_  
 Have you retained an attorney?  No  Yes Name & Address: \_\_\_\_\_

**PLEASE GIVE MOST CURRENT DATE**  
 Spinal Exam: \_\_\_\_\_  
 MRI Exam: \_\_\_\_\_  
 X-ray Exam: \_\_\_\_\_  
 Lab Exam: \_\_\_\_\_  
 Last Physical: \_\_\_\_\_  
**FEMALE ONLY**  
 Pap smear: \_\_\_\_\_  
 Breast Exam: \_\_\_\_\_  
 Implants: \_\_\_\_\_  
**DOCTOR'S USE ONLY**



LEFT

**Severity of Pain**

List region of pain and circle severity number. 1=least, 10=greatest

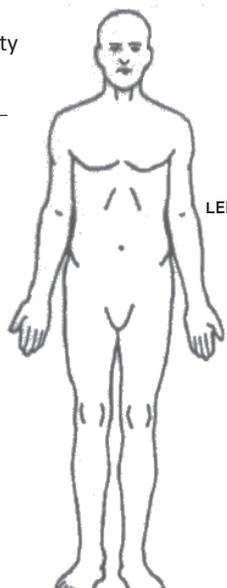
ex. Neck

1 2 3 4 5 6 7 8 9 10

**MARK PAIN AREA**

+++ Burning  
 000 Stabbing  
 --- Sharp  
 III Constant

1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_



LEFT

Please mark area of pain on the drawing using the code listed above

<p><b>HABITS</b></p> <p><input type="checkbox"/> Smoking Packs/day: _____</p> <p><input type="checkbox"/> Drinking Alcohol: _____</p> <p><input type="checkbox"/> Coffee Cups/day: _____</p> <p><input type="checkbox"/> Never smoker</p> <p><input type="checkbox"/> Former smoker</p>	<p><b>EXERCISE</b></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Moderate</p> <p><input type="checkbox"/> Daily</p>
---	--

**FAMILY HISTORY**

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/> Yes				
Father	<input type="checkbox"/> Yes				
Brother, # of	<input type="checkbox"/> Yes				
Sister, # of	<input type="checkbox"/> Yes				

**HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?**

<input type="checkbox"/> 541 Appendicitis	<input type="checkbox"/> 285.9 Anemia	<input type="checkbox"/> 429.9 Heart Disease	<input type="checkbox"/> 716.9 Arthritis
<input type="checkbox"/> 541 Pneumonia	<input type="checkbox"/> 285.9 Measles	<input type="checkbox"/> 429.9 Goiter	<input type="checkbox"/> 716.9 Epilepsy
<input type="checkbox"/> 541 Polio	<input type="checkbox"/> 285.9 Chicken Pox	<input type="checkbox"/> 429.9 Pleurisy	<input type="checkbox"/> 716.9 Lumbago
<input type="checkbox"/> 541 Tuberculosis	<input type="checkbox"/> 285.9 Diabetes	<input type="checkbox"/> 429.9 Alcoholism	<input type="checkbox"/> 716.9 Eczema



Please select the following signs and symptoms that apply or have applied to you. Leave blank if never. A complete history and understanding of your health will facilitate care.

**GENERAL SYMPTOMS**

- 784.0 Headache
- 780.6 Fever
- 780.9 Chills
- 780.8 Night Sweats
- 780.2 Fainting
- 780.4 Dizziness
- 780.3 Convulsions
- 780.52 Loss of Sleep
- 780.7 Fatigue
- 799.2 Nervousness
- 783 Loss of Weight
- 782 Numbness or pain in arms/legs/hands
- 995.3 Allergy (What)
- 786.09 Wheezing
- 729.2 Neuralgia

**GASTRO-INTESTINAL**

- 783 Poor Appetite
- 536.8 Poor Digestion
- 994.2 Excessive Hunger
- 787.3 Belching or Gas
- 787 Nausea
- 787 Vomiting
- 578 Vomiting Blood
- 536.8 Pain over Stomach
- 564 Constipation
- 558.9 Diarrhea
- 789 Colon Trouble
- 455.6 Hemorrhoids (Piles)
- 785.1 Liver Trouble
- 782.4 Jaundice
- 575.9 Gall Bladder Trouble

**EYE/EAR/NOSE/THROAT**

- 368.9 Poor Vision
- 378.9 Crossed Eyes
- 379.91 Pain in Eyes
- 389.9 Deafness
- 388.70 Earache
- 388.30 Ear Noises
- 388.60 Ear Discharges
- 478.1 Nasal Obstruction
- 784.7 Nose Bleeds
- 462 Sore Throat
- 784.49 Hoarseness
- 477.9 Hay Fever
- 493.9 Asthma
- 460 Frequent Colds
- 240.9 Enlarged Thyroid
- 463 Tonsillitis
- 686.9 Sinus Trouble

**RESPIRATORY**

- 786.2 Chronic Cough
- 786.3 Spitting Blood
- Spitting Phlegm
- 786.50 Chest Pain
- 786.09 Difficulty Breathing

**GENITO-URINARY**

- 788.3 Frequent Urination
- 788.1 Painful Urination
- 599.7 Blood in Urine
- 592 Kidney Infection
- 788.3 Bed Wetting
- 788.2 Inability to control Urine
- 601.9 Prostate Trouble

**MUSCLE & JOINTS**

- Weakness
- Twitching
- 847 Stiff Neck
- 722.10 Backache
- 719 Swollen Joints
- 781 Tremors
- 729.5 Foot Trouble
- 724.79 Painful Tail Bone
- 724.5 Pain between Shoulders
- 563.3 Hernia

**CARDIO-VASCULAR**

- 783 Rapid Heart
- 427.89 Slow Heart
- 401.9 High Blood Pressure
- 458.9 Low Blood Pressure
- 786.51 Pains over Heart
- 438 Previous Heart Trouble
- 719.07 Swelling Ankles
- 759.9 Poor Circulation
- Varicose Veins
- Stroke(s)

**SKIN OR ALLERGIES**

- 368.9 Skin Eruptions
- 698.9 Itching
- 278.8 Bruising Easily
- 701.1 Dryness
- Boils
- 782 Sensitive Skin
- 708.9 Hives or Allergy
- 692.9 Eczema

**FOR WOMEN ONLY**

- 786.2 Painful Periods
  - 626.2 Excessive Flow
  - 626.4 Irregular Cycle
  - 627.2 Hot Flashes
  - 625.3 Cramps or Backaches
  - 634.9 Miscarriage
  - 623.5 Vaginal Discharge
  - Pregnant at this time
  - Last Pap
- By who \_\_\_\_\_

**OPERATIONS AND PROCEDURES**

DATE _____	Vaccinations _____	DATE _____	Tubes in Ears _____	DATE _____	Sinus _____
_____	Tonsillectomy _____	_____	Appendectomy _____	_____	Hernia _____
_____	Gall Bladder _____	_____	Female Organs _____	_____	Thyroid _____
_____	Back Operation _____	_____	Rectal Surgery _____	_____	Stomach _____
_____	Other _____	_____	Other _____	_____	Other _____

List any accidents or falls and dates:  Car: \_\_\_\_\_  Recreational Vehicle: \_\_\_\_\_  Sports: \_\_\_\_\_  
 School: \_\_\_\_\_  Other: \_\_\_\_\_

List any broken bones or dislocations (fractions): \_\_\_\_\_

Ever on crutches?  No  Yes Why? \_\_\_\_\_

Have you ever had any spinal taps or spinal injections?  Yes  No

Were you ever knocked unconscious?  Yes  No

Do you suffer from any condition other than that for which you are now consulting us? \_\_\_\_\_

Are you presently taking any medication-prescription or patent?  No  Yes what drugs? \_\_\_\_\_

Are you allergic to anything? \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that He/she is responsible for all 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 understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one half percent (1 1/2%) per month to any balance owed and in the event of default to pay reasonable collection charges and/or attorney fees.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Family Life Chiropractic Center



## Release of Medical and Billing Information

We may use and disclose health information about you for the purpose of treatment, payment, or healthcare without your permission as defined in our Notice of Privacy Practices.

This consent form is designed specifically for family, friends, caregivers and insurance companies who may at times request information about you. **Please be advised if this form is left blank we will assume you do not want any information released.**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I hereby give my consent for the office Family Life Chiropractic Center to release my Medical and/or Billing information to the following persons.

NAME _____	RELATIONSHIP: _____
_____	_____
_____	_____

- Current insurance company(s)
- Anyone identifying themselves as a family member or friend
- Do not release any medical or billing information to anyone without contacting me first.

Specific request if any:  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

This consent form may be amended at any time by the patient. Please ask the receptionist for a new form

**All current consent forms remain in the patient's chart.**

351 East Highland Street  
Blue Ridge, GA 30513  
Office: (706)632-2707  
Fax: (706) 632-2723

3000 Hwy 64 W. Ste 120  
Murphy, NC 28906  
Office: (828) 835-7997  
Fax: (828) 835-3477

314 Northcutt Rd.  
Ellijay, GA 30540  
Office: (706) 276-1099  
Fax: (706) 276-1045



## INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of healthcare, offers considerable benefits but may also have some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one per one million to one per two million cervical spine (neck) adjustments, is a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and your spine health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ Patient Name (please print)	_____ Relationship to Patient
_____ Patient/Legal Guardian's Signature	_____ Date
_____ Witness Signature	_____ Date

**Three Locations to Serve You**  
**Blue Ridge: 706-632-2707**  
**Murphy: 828-835-7997**  
**Ellijay: 706-276-1099**  
**Website: [AreYouLivingLife.Com](http://AreYouLivingLife.Com)**