FAMILY FIRST CHIROPRACTIC PC

PATIENT INFORMATION – Please Print Clearly

How did you learn about our office? _____

Patient Last Name: _____ First Name: _____ Middle Initial: ____

Name you preferred to be called: _____ Email Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: (H): _____ (W): _____ (C): _____

Check best number to be reached at: ☐Home ☐Work ☐Cell

Age: ____ Date of Birth: _____ SSN: _____ and/or Driver's Lic# _____

☐Male ☐Female ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Partners

Do you have children: ☐Yes ☐No If yes, list their ages: _____

Occupation: _____ Name of Employer: _____ Years Employed: ____

Employed: ☐Full Time ☐Part Time ☐Retired ☐Not Employed **Students**: ☐Full Time ☐Part Time

Family Medical Doctor: _____ Phone: _____

Emergency Contact: ☐Spouse ☐Legal Guardian ☐Partner ☐Friend ☐Other: _____

Name: _____ Phone: _____

PAYMENTS ARE DUE WHEN SERVICES ARE RENDERED OR PRODUCTS ARE PURCHASED.

Payment for service will be by: ☐Cash ☐Visa ☐Mastercard ☐Discover ☐American Express

****No Checks Accepted. ****

WE DO NOT BILL THIRD PARTY OR PRIVATE INSURANCE DIRECTLY. We can provide you with a super bill that you can submit to your insurance company for POSSIBLE reimbursement. We are out of network with all insurance companies. We are a non-participating provider with Medicare. We will submit your Medicare claims for you on your behalf.

_____ _____ _____

Patient's Name (PRINTED) Patient/Parent/Guardian's Signature Date

Family First Chiropractic PC Dr. Ryan Gutierrez 4131 Camino Coyote Ste B Las Cruces, NM 88011
(575) 521 -1215

FAMILY FIRST CHIROPRACTIC PC

PATIENT CASE HISTORY- Please print clearly and fill in completely.

Have you ever visited a Chiropractor? ☐Yes ☐No If yes, Whom: _____ Time under care? _____

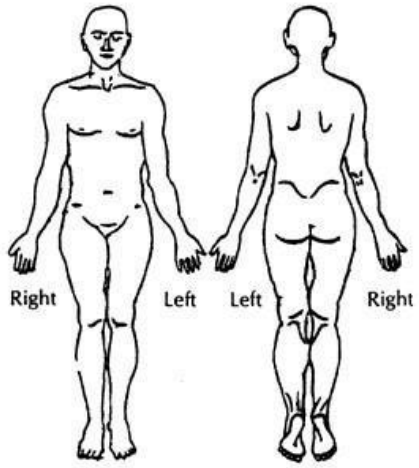
What brought you into our office today? _____

Onset

When did the complaint start? Date: _____ GRADUALLY/SUDDENLY (circle one)

Please describe what happened: _____

_____



Please mark all areas of discomfort:

Which complaint concerns you the most?

Major Complaint: _____

2nd Complaint: _____

3rd Complaint: _____

Provoking and Palliative

What makes your condition **worse**? ☐Nothing ☐Lifting ☐Trying to Stand ☐Standing ☐Lying Down ☐Walking ☐Sitting ☐Movement ☐Exercise ☐Inactivity ☐Work Activities ☐Ice ☐Heat

Is it **worse** in the: ☐Morning ☐During Work/Daytime ☐Evening/After Work ☐At night

What makes your condition **better**? ☐Nothing ☐Standing ☐Walking ☐Sitting ☐Movement/Exercise ☐Inactivity ☐Lying Down ☐Sleep ☐Hot Shower ☐Stretching ☐Ice ☐Heat ☐Pain Meds

Overall, has your condition been getting: ☐Better ☐Worse ☐No Change

Have you ever had anything like this before? ☐Yes ☐No If Yes, explain _____

Has there been any change in your bodily functions: ☐Urination ☐Defecation ☐Respiration ☐Digestion ☐Vision ☐Sexual ☐Other, explain _____

Quality

Describe the sensation you feel: ☐Dull ☐Achy ☐Sharp ☐Shooting Pain ☐Burning ☐Throbbing ☐Other, please describe: _____

How would you rate the intensity (severity) of your complaint on a scale of 0-10 **now**? _____

And at the **worst since it started**? _____

Radiating

Do you experience PAIN or NUMBNESS or TINGLING (circle all that apply) radiating/traveling to other body parts? ☐YES ☐NO ☐Down the Arms ☐Down the Legs

_____ _____ _____

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PATIENT CASE HISTORY- Please print clearly and fill in completely.

Timing

Is the pain: ☐Constant(76-100% of day) ☐Frequent(51-75%) ☐Occasional(26-50%) ☐Intermittent(0-25%)

Have you missed any work or school days due to this condition? ☐Yes ☐No If yes, how many? _____

Have you seen any other doctors for this condition? ☐Yes ☐No

If yes, then who, and what was the treatment: _____

Are you taking any prescription medications for this condition? ☐Yes ☐No

If yes, please list them here: _____ Have they helped? ☐Yes ☐No

Are you taking any over the counter/non-prescription medications or home remedies for this condition?

☐Yes ☐No If yes, have they helped? ☐Yes ☐No

If yes, please list them here: _____

Habits

Smoking Status, please check one: ☐Never a smoker ☐Current every day smoker (_____ packs per day)

☐Current Periodic Smoker (how often _____) ☐Former smoker (year quit _____)

Do you drink alcohol? ☐Yes ☐No If yes, _____ drinks per day/month (please circle)

Do you drink caffeine? ☐Yes ☐No If yes, how much? _____ How often? _____

How often do you exercise? ☐Daily ☐ 2-5x's/week ☐ I don't exercise

How long do your exercise workouts last? ☐ >1 hour ☐ 1 hour ☐ 30 min's ☐ <30 min's ☐ NA

What are your exercise activities? ☐Walking ☐Running/Treadmill/Rowing/Climbing ☐Swimming

☐Weights ☐Stretching ☐Yoga/Pilates ☐Biking ☐Group Exercise ☐Other _____

☐Right Handed ☐Left Handed Sleep Habits: _____ hours/night Position: ☐Back ☐Side ☐Stomach

Family History of:

Family Member	Diseases in the family? (Arthritis, Heart Disease, Cancer, Diabetes, MS, Stroke, Dementia)	Living or Deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfathers(s)		

_____ _____ _____

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PATIENT MEDICAL HISTORY- Please print clearly and fill in completely. Have you ever had any of the following? Please write "**P**" for **PAST** and "**C**" for **CURRENTLY EXPERIENCING**. Leave line blank if not applicable.

General Symptoms

_____ Headache
_____ Fever
_____ Chills
_____ Night Sweats
_____ Fainting
_____ Dizziness
_____ Convulsions
_____ Loss of Sleep
_____ Fatigue
_____ Nervousness
_____ Loss of Weight
_____ Wheezing
_____ Neuralgia
_____ Numbness or pain in arms/legs/hands

Muscle/Joints

_____ Weakness
_____ Twitching
_____ Stiff Neck
_____ Backache
_____ Swollen Joints
_____ Tremors
_____ Foot Trouble
_____ Painful Tailbone
_____ Pain between Shoulders
_____ Hernia
_____ Scoliosis

Cardiovascular

_____ Rapid Heart
_____ Slow Heart
_____ High BP
_____ Low BP
_____ Pain over Heart
_____ Previous Heart Trouble
_____ Swelling Ankles

GI

_____ Poor Appetite
_____ Poor Digestion
_____ Excessive Hunger
_____ Belching or Gas
_____ Nausea
_____ Vomiting
_____ Vomiting Blood
_____ Pain over Stomach
_____ Constipation
_____ Diarrhea
_____ Colon Trouble
_____Hemorrhoids
_____ Liver Trouble
_____ Jaundice
_____ Gall Bladder Issues

EENT

_____ Poor Vision
_____ Crossed Eyes
_____ Pain in Eyes
_____ Deafness
_____ Earache
_____ Ear Discharges
_____ Nasal Obstruction
_____ Nose Bleeds
_____ Sore Throats
_____ Hoarseness
_____ Hay Fever
_____ Asthma
_____ Frequent Colds
_____ Enlarged Thyroid
_____ Tonsillitis
_____ Sinus Trouble

Respiratory

_____ Chronic Cough
_____ Spitting Blood
_____ Poor Circulation
_____ Spitting Phlegm
_____ Varicose Veins
_____ Chest Pain
_____ Strokes
_____ Difficulty Breathing

Skin or Allergies

_____ Pimples
_____ Itching
_____ Bruising Easily
_____ Dryness
_____ Boils
_____ Sensitive Skin
_____ Hives or Allergy
_____ Eczema
_____ Allery to Meds

Genito-Urinary

_____ Frequent Urination
_____ Painful Urination
_____ Blood in Urine
_____ Kidney Infection
_____ Bed Wetting
_____ Inability to Control Urine
_____ Prostate Trouble

Brain/Head

_____ Knocked Unconscious
_____ Lapse of Memory

For Women Only

_____ Painful Periods
_____ Excessive Flow
_____ Irregular Cycle
_____ Hot Flashes
_____ Cramps or Backaches
_____ Miscarriage
_____ Vaginal Discharge
_____ Currently Pregnant
_____ Use of oral Contraception

What kind and for how long? _____
_____

Skeletal

_____ Neck Pain
_____ Mid Back Pain _
___ Low Back Pain
_____ Shoulder Pain
_____ Jaw Pain
_____ Elbow Pain
_____ Wrist/Hand Pain
_____ Hip Pain
_____ Knee Pain
_____ Foot/Ankle Pain

Diseases

_____ Appendicitis
_____ Pneumonia
_____ Rheumatic Fever
_____ Polio
_____ Tuberculosis
_____ Whooping Cough
_____ Stroke
_____ Anemia
_____ Measles
_____ Mumps
_____ Chicken Pox
_____ Diabetes
_____ Cancer-
What type? _____
_____ Whiplash
_____ Heart Disease
_____ Goiter
_____ Influenza (flu)
_____ Pleurisy
_____ Alcoholism
_____ Venereal Infection
_____ Hypertension
_____ Arthritis
_____ Epilepsy
_____ Mental Disorder
_____ AIDS
_____ Osteoporosis
_____ Osteopenia

_____ _____ _____

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PATIENT MEDICAL HISTORY- Please print clearly and fill in completely.

List ALL Past Surgeries and Year Performed: _____

_____

_____

List ALL Past Injuries and Year (Include Auto, Work, Home, Fractures, Sports Injuries): _____

_____

_____

List ALL Prescription Medications, Non-Prescription Medications, Supplements and Home Remedies you are currently using and dosage for each: _____

_____

_____

List ALL allergies to Food, Medication and other factors: _____

_____

List any other health issues, not previously mentioned, that the doctor should be aware of: _____

_____

_____

I agree that it is my responsibility to complete these clinic forms accurately. It is my responsibility to notify the doctor if any of my information has changed or requires an update.

_____ _____ _____

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FFC
FAMILY FIRST CHIROPRACTIC PC

APPOINTMENT POLICY

In order to provide you and our other patients with the best optimal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. **Be on time for your appointments.** We strive to see all of our patients at their scheduled time, running late for your appointment will either push back our subsequent patients or cause you to have to wait until the doctor is able to see you. Please remember that we have reserved appointment times especially for you. Therefore, **we request at least 24 hour notice in order to reschedule your appointment**. This will allow us to offer that cancelled time to another patient. When you cancel your appointment at the last minute, everyone loses- you, the doctor and other patients that would have utilized your appointment time. Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time.

_____ _____ _____

Patient's Name (PRINTED) Patient/Parent/Guardian's Signature Date

FINANCIAL POLICY

I clearly understand and agree that all serviced rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Cash Patients

All payments are due at the time of service, unless prior arrangements have been made. Any balance left over 30 days may be subject to a 5% interest charge. **CHECKS ARE NOT ACCEPTED.**

Medicare Patients and Insurance Patients

We are a **NON-PARTICIPATING PROVIDER WITH MEDICARE**. We MUST have a copy of your Medicare Card and Driver's License to file your claims on your behalf. Medicare will only cover and reimburse for a limited number of ACUTE chiropractic care visits. Maintenance care is not covered and no reimbursement will be offered to the patient from Medicare.

We **DO NOT** process any other insurance in our office. We are an **OUT-OF-NETWORK PROVIDER** according to your plan description. We can print you an itemized Superbill for **YOU** to submit for **POSSIBLE** reimbursement.

Product Purchases

All products must be paid for at the time they are received (in stock items) or ordered (custom products, such as orthotics).

The above mentioned policies were designed to make things easier for all of us. Thank you for your cooperation. By signing below, the patient agrees to abide by the policies listed above.

_____ _____ _____

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FAMILY FIRST CHIROPRACTIC PC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including, but not limited, to examination tests, diagnostic x-Ray(s) and physical therapy techniques (including Rock Tape application), on me (or on the patient named below, for whom I am legally responsible) which are recommended by
Dr. Ryan Gutierrez and/or other licensed Doctors of Chiropractic who will now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Family First Chiropractic.

The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms. While rare, in the practice of chiropractic there are some risks to treatment including, but not limited to: sprains/strains, increased symptoms or pain, no improvement of symptoms or pain, fractures, disc injuries, strokes, dislocations, and serious neurological impairment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter nonchiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the body's nerve system. Our only method is specific adjusting to correct subluxations (misalignments).

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 on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read and fully understand the above statement. I have also had an opportunity to ask questions and all of my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek care.

_____ _____ _____

Patient's Name (PRINTED) Patient's Signature Date

CONSENT TO EVALUATE AND TREAT A MINOR (TREATMENT OF A CHILD UNDER 18 YRS)

I, _____, being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. I understand and agree that all services rendered to my child are charged directly to me and that I remain personally responsible for payment.

_____ _____

Parent/Legal Guardian's Signature Date

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HIPAA CONSENT AND ACKNOWLEDGEMENT

I acknowledge that Family First Chiropractic's HIPAA (Notice of Privacy Practices) has been provided to me.

The Notice of Privacy Practices describes the uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Family First Chiropractic. The Notice of Privacy Practices also describes my rights and Family First Chiropractic's duties with respect to my protected health information.

Family First Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices pursuant to HIPAA.

_____	_____	_____
Patient's Name (PRINTED)	Patient's Signature	Date

If patient is a minor or under a guardianship order as defined by State Law:

_____	_____	_____
Patient's Name (PRINTED)	Parent/ Legal Guardian's Signature	Date

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