



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Married Single Divorced Widowed Kids: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Childhood History: Circle all that apply**

- |  |     |    |
|--|-----|----|
| Did you have any childhood illnesses?                                      | Yes | No |
| Did you have any serious falls as a child?                                 | Yes | No |
| Did you play youth sports?   | Yes | No |
| Did you take Medications?  | Yes | No |
| Did you have surgery?  | Yes | No |
| Have you fallen / jumped from a height over three feet?                    | Yes | No |
| Were you in any car accidents as a child?                                  | Yes | No |
| Was there any prolonged use of medicine such as antibiotics or an inhaler? | Yes | No |
| Did you suffer any other traumas (physical or emotional)                   | Yes | No |
| As a child, were you under regular chiropractic care?                      | Yes | No |

**Please share any additional information:**

\_\_\_\_\_  
\_\_\_\_\_

**Adult – (18 to present)**

Do/did you smoke? Yes No

Do/did you drink alcohol? Yes No

Have you been in any accidents? Yes No

Have you had any surgery? Yes No

If yes, list here: \_\_\_\_\_  
\_\_\_\_\_

Do/did you play adult sports? Yes No

On a scale of 1 – 10 describe your stress level:  
(1 = none / 10 = extreme)

Occupational: \_\_\_\_\_ Personal: \_\_\_\_\_

**Rate these following as Poor, Good, Excellent:**

Diet: \_\_\_\_\_ What do you eat? \_\_\_\_\_

Exercise: \_\_\_\_\_ When and what? \_\_\_\_\_

Sleep: \_\_\_\_\_ Hours per day? \_\_\_\_\_

General Health: \_\_\_\_\_

Please list any medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Addressing issues that may have brought you to our office**

If you have no symptoms or complaints, and are here for wellness services, please check here: \_\_\_\_\_  
and then skip to Family Health Profile. Otherwise please briefly explain what brought you to our office today:

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**Does this interfere with:** \_\_\_Work \_\_\_Sleep \_\_\_Walking \_\_\_Hobbies \_\_\_Leisure \_\_\_Other

**Have you seen anyone else for this issue?** \_\_\_yes \_\_\_no If yes, who? \_\_\_\_\_

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**Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in ears          | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Stiff Neck               | <input type="checkbox"/> Cold Hands             | <input type="checkbox"/> Cold Feet       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Hot Flashes     |
| <input type="checkbox"/> Cold Sweats              | <input type="checkbox"/> Lights bother eyes       | <input type="checkbox"/> Urinary Problem        | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood Swings              | <input type="checkbox"/> Menstrual Pain           | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers          |

**Family Health Profile:**

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Father: \_\_\_\_\_  
Brother(s): \_\_\_\_\_  
Sister (s): \_\_\_\_\_  
Others: \_\_\_\_\_

**Do you:**

Drink Bottled water?	Yes	No
Belong to health club?	Yes	No
Use vitamins?	Yes	No
Watch more than 5 hours of TV a week?	Yes	No
Spend 1 or more hours on a computer daily ?	Yes	No
Drink Soda?	Yes	No (Diet or Regular)

Your nervous system is the master system and controller of your body. Health and wellness are therefore mediated through your nervous system. What makes our office different is that we have a unique and modern approach to supporting and expanding your health by improving how your nervous system performs. The Neurospinal Function Index (NSFi), which is the rating of results of the series of tests, scales from 0-100. The higher your score, the better your NSFi.

A graph representing this is below.

**On the graph to the right:**

1. Please put an 'X' to score where you think you are today
2. Please circle where you would like to be (your goal)
3. How long do you think it will take to get where you circled? \_\_\_\_\_
4. What things might you need to change to help you reach you goal?
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  - d. \_\_\_\_\_



If we could make recommendations that would not only address your main concerns, but also help you with improving your overall health, would you like to hear them? Yes  No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

*Back Cove Family Chiropractic, Inc.*  
*298 Main Street*  
*Yarmouth, ME 04096*

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**TERMS OF ACCEPTANCE**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

**Adjustment:** The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

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**Consent to evaluate and adjust a minor child**

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.

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)



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# PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

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With my consent, Upper Cervical Health Centers Of America may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Upper Cervical Health Centers of America Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. UCHCA reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to UCHCA.

With my consent, UCHCA may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, UCHCA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Upper Cervical Health Centers of America's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Upper Cervical Health Centers Of America may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

## *Authorization To Pay Doctor/Clinic*

I hereby authorize and direct payment of any medical 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 photo static copy of this agreement shall serve as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Authorization to Pay/Release Is Granted to:

Upper Cervical Health Centers Of America