EASTON FAMILY CHIROPRACTIC

PLEASE PRINT CLEARLY AND FILL ALL PAGES COMPLETELY

Name:_____ **Age:**_____ **Date of Birth:**_____/_____/_____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone:_____ **Email:**_____

Health History: I'm here for: □ Pain/Health Concern □ Wellness □ Auto Accident

Problem area(s):_____ **Work Related?** □ Yes □ No

Date of Onset:_____ □ Sudden □ Gradual **Duration:**□ Hours □ Days □ Months □ Years

Pattern of Problem:

□ Constant	□ Frequently	□ Intermittent	□ Occasional
75%-100% of the day	50%-75% of the day	25%-50% of the day	0%-25% of the day

How did the pain start? _____

What makes it better? _____

What makes it worse? _____

Personal & Family History:

List any current medications:_____

COVID Vaccine: □ Yes □ No **Tobacco Use:** □ Yes □ No

List any past surgeries: _____

List any past accidents:_____

Occupation:_____ **Employer:**_____

Chiropractic History

Have you ever been to a chiropractor before? □ Yes □ No **If Yes: Doctor's Name:**_____

Date of last chiropractic visit?_____ **Reason for care:**_____

Date of last chiropractic x-rays:_____ **How long were you under care?**_____

Where did you hear about our office?_____

Please check any that apply:

Condition, Symptom or problem	Constant or Frequent	Occasional or Sometimes
Grating/Grinding Neck	□	□
Neck Pain	□	□
Shoulder Pain	□	□
Arm/Hand Pain	□	□
Mid Back Pain	□	□
Low Back Pain	□	□
Hip Pain	□	□
Leg/Foot Pain	□	□
Disc Problems	□	□
Arthritis	□	□
Other Joint Pain	□	□
Numbness	□	□
Cold Hands/Feet	□	□
Pins and Needles	□	□
Headaches	□	□
Migraines	□	□
Dizziness	□	□
Ringing in the Ears	□	□
Earaches	□	□
Hearing Loss	□	□
Sinus Trouble	□	□
Frequent Colds	□	□
Difficulty Breathing	□	□
Allergies	□	□
Asthma	□	□
Chronic Cough	□	□
Chest Pains	□	□
Heart Problems	□	□
High Blood Pressure	□	□
Low Blood Pressure	□	□
Digestive Problems	□	□
Urinary Problems	□	□
ADD/ADHD	□	□
Diabetes	□	□
Cancer	□	□
Loss of Sleep	□	□
Faulty Posture	□	□
Painful Menstrual Cycles	□	□
Irregular Menstrual Cycles	□	□

Pregnant at this time? □Yes □No

Other:_____

_____

_____

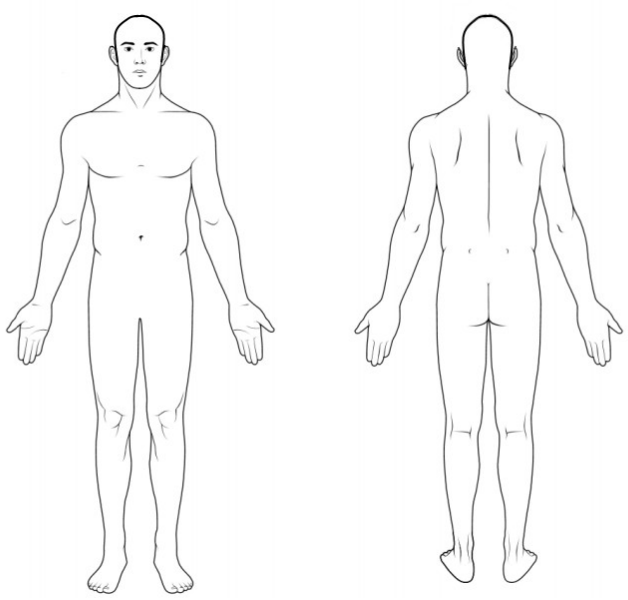
_____

I certify that this information is accurate and correct to the best of my knowledge.

_____

Signature Date

Circle the areas where you have any problems, pain or discomfort.



Please fill in any other health information you feel we might need for your care.

_____

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_____

I hereby notify all concerned, that I neither suspect nor know positively at this time that I may be pregnant. I release this clinic and its doctors from any and all damages arising from any and all procedures, of a diagnostic or treatment nature with reference to the possibility of pregnancy.

_____

Signature Date

FINANCIAL RESPONSIBILITY STATEMENT

Are you going to use your insurance? Yes□ No□

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Greg Kulesza and Easton Family Chiropractic, LLC will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Dr. Greg Kulesza and Easton Family Chiropractic, LLC will be credited to my account upon receipt. If covered by insurance, I clearly understand that I am responsible for my co-payments and deductible.

However, if I have no insurance coverage, I clearly understand and agree that all services rendered are directly charged 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.

Chiropractic and the professionals of this office make no claim to cure any condition, but only to adjust subluxations (misalignments of the spine) thus restoring better nerve supply for restoration of health.

REGARDING NOTICE OF YOUR RIGHT TO PRIVACY

Please scan the QR code for full privacy notice.
If you are unable to do so, a paper copy is available for your review.

I was offered to receive or have received a copy of Easton Family Chiropractic's Patient Privacy Notice and understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

THE MATERIAL RISKS INHERENT WITH CHIROPRACTIC CARE

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulations and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains, and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.

_____ _____
Patient signature Date

_____
Patient Name Print

_____ _____
Witness Date