EASTON FAMILY CHIROPRACTIC PLEASE PRINT CLEARLY AND FILL ALL PAGES COMPLETELY

Name:		_Age:I	Date of Birth:	<u> </u>
Street Address:		City:	State	:Zip:
Phone:	Email:			
Health History:	I'm here for: □ Pain/Health	Concern 🗆 We	llness 🗆 Auto) Accident
Problem area(s):	Work Related? □ Yes □ No			
Date of Onset:	🗆 🗆 Sudden 🗆 Gradual	l Duration:	Hours 🗆 Days 🗆	Months
Pattern of Problem:				
□ Constant 75%-100% of the day	□ Frequently 50%-75% of the day	□ Intermittent 25%-50% of the da	□ C y 0%-2	Occasional 5% of the day
How did the pain star	rt?			
What makes it better	?			
What makes it worse	?			
Personal & Fam	nily History:			
List any current med	ications:			
COVID Vaccine: 🗆 Y	Xes □ No Tobacco Use:	□ Yes □ No		
List any past surgerie	es:			
List any past acciden	ts:			
Occupation:		Employer:		
Chiropractic Hi Have you ever been t	story o a chiropractor before?	s 🗆 No If Yes: Doc	tor's Name:	
Date of last chiroprac	ctic visit?	_Reason for care:		
Date of last chiroprac	ctic x-rays:	_How long were y	ou under care?	
Where did vou hear a	about our office?			

Please check any that apply:

Condition, Symptom	Constant or	Occasional or	
or problem	Frequent	Sometimes	
Grating/Grinding Neck			
Neck Pain			
Shoulder Pain			
Arm/Hand Pain			
Mid Back Pain			
Low Back Pain			
Hip Pain			
Leg/Foot Pain			
Disc Problems			
<u>Arthritis</u>			
Other Joint Pain			
Numbness			
Cold Hands/Feet			
Pins and Needles			
Headaches			
Migraines			
Dizziness		F	
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			
<u>Urinary Problems</u> ADD/ADHD			
Diabetes	—		
Cancer		<u>_</u>	
Loss of Sleep		_	
Faulty Posture			
Painful Menstrual Cycles			
Irregular Menstrual Cycles			
	Ц		
	Vee	NI-	

Pregnant at this time?

□No

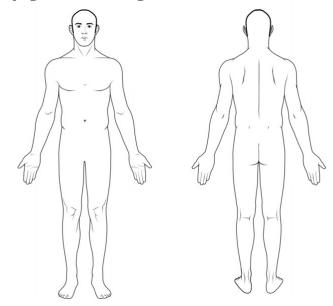
Other:

I certify that this information is accurate and correct to the

⊔Yes

best of my knowledge.

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.

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

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

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