Gulf Coast Family Chiropractic
Dr. Alicia Barton

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Promoting Health from the inside out!!

The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods.

Please complete this confidential health questionnaire fully and accurately in Blue or Black Ink Only. The more we know about the overall picture of your health, the better we will be able to help you.

Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly, to help us determine potential causes and effects of subluxations in your case.

If you have any questions, please don't hesitate to ask for guidance.

Experience with Chiropractic Care

Which patient referred you to this office?_____

Have you ever been adjusted by another Chiropractor?
☐Yes ☐ No

Reason for those visits?

_____

_____

Were X-rays taken? ☐ Yes ☐ No

Did your family receive chiropractic care?
☐ Yes ☐ No ☐ N/A

Chiropractor's Name: _____

Approximate date of last visit: _____

Primary Language:_____ Race:
☐American Indian or Alaskan Native ☐ Asian ☐White
☐Black / African American ☐Other_____
☐Native Hawaiian or Pacific Islander ☐Decline

Ethnicity:
☐Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

Patient Information

Name:_____

Street Address:_____

City:_____State:_____Zip:_____

Email:_____

Home Phone:( )____-_____ Cell Phone:( )____-_____

Work Phone: ( )____-_____ Ext: ____

Social Security Number: _____-_____-_____
Insurance Provider: _____
Subscribers Name: _____
Contract Number: _____

Group #: _____ PH #: _____

Birthdate: ___-___-_____ Age: ____

Height: _____ Weight: _____

Gender: ☐ Male ☐ Female # of Children:

Marital Status: ☐Single ☐Married ☐Separated
☐Divorced ☐Widowed ☐Common Law

Name of Spouse/Significant Other: _____

My Occupation: _____
Employer: _____

Goals For My Care

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for the correction of whatever is malfunctioning in their bodies. We will weigh your needs and desires when making recommendations for care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care - symptomatic relief of pain or discomfort.

☐ Corrective Care - correcting and relieving the cause of the problem as well as the symptoms.

☐ Comprehensive Care - bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic adjustments.

☐ I want the Doctor to select the type of care appropriate to my health status.

_____ ____/____/_____
(signature) (date)

PLEASE FILL OUT THE APPROPRIATE PORTIONS IF YOU HAVE AN: INFANT / CHILD / ADOLESCENT

CHILD'S NAME:_____ **DOB:**_____ **DATE:**_____ **HR#:**_____

For an ***Infant*** please fill out the **AND** sections.

For a ***Child/Adolescent*** please fill out the **AND** sections. **The items/sections are for OFFICE USE.**

HISTORY FROM BIRTH ON		
BIRTH - NORMAL	Y	N
FULL TERM	Y	N
COMPLICATIONS	Y	N
MIDWIFE/OBGYN	Y	N
HOSPITAL/OBGYN	Y	N
EPIDURAL	Y	N
INDUCED	Y	N
FORCEPS	Y	N
VACUUM	Y	N
C-SECTION	Y	N
SKIN TO SKIN CONTACT?	Y	N
HOW LONG?		
DELAYED CORD CUTTING?	Y	N
APGAR SCORE		
-AT 5 MIN		
BREAST FED	Y	N
-HOW LONG		
-FORMULA AFTER	Y	N
CONSUME ALCOHOL	Y	N
-HOW MUCH		
SMOKE	Y	N
-HOW MUCH		
-HOW LONG		
MEDICATIONS DURING PREGNANCY	Y	N
VACCINES	Y	N
-LAST ONE		
REACTIONS	Y	N
WERE YOU INFORMED YOU HAD A CHOICE FOR VACCINES?	Y	N
WOULD YOU LIKE INFO	Y	N

SUBJECTIVE INFANT		
COLIC	Y	N
EAR INFECTIONS	Y	N
ACID REFLUX	Y	N
BOWEL ISSUES	Y	N
DECREASED IMMUNE FUNCTION	Y	N
ASTHMA		
ALLERGIES	Y	N
FALL FROM CH TABLE	Y	N
TUMBLE DOWN STAIRS	Y	N
FALL OUT OF CRIB	Y	N
INVOLVED IN CAR ACCIDENT	Y	N
SLEPT IN SWING	Y	N
PLAY IN JOLLY JUMPER	Y	N
TONSILITIS	Y	N
REACT TO VACCINATION	Y	N
FREQ CRYING SPELLS	Y	N
FREQ FEVERS	Y	N
FREQ BOUTS OF DIARRHEA	Y	N
CONSTIPATION	Y	N
SLEEPING PROBLEMS	Y	N
FREQ COLDS	Y	N
DID NOT GAIN WEIGHT	Y	N
OTHER	Y	N

OBJECTIVE INFANT		
CRANIAL CIRCUMF	L	R
REVERSE FENCER + -	L	R
POSTURE		
LEG LENGTH	L	R

OBJECTIVE CHILD - ADOLESCENT		
HEAD ROTATION	L	R
HEAD TILT	L	R
HIGH SHOULDER	L	R
T/S TRANS	L	R
HIGH HIP	L	R
PELVIC ROTATION	L	R
LLEG LENGTH	L	R
SACRAL MOVEMENT	L	R
PDSC	L	R

SUBJECTIVE CHILD - ADOLESCENT		
ASTHMA	Y	N
ALLERGIES	Y	N
ACID REFLUX	Y	N
BOWEL ISSUES	Y	N
EAR INFECTIONS	Y	N
GROWING PAINS	Y	N
HEADACHES	Y	N
PAIN	Y	N
FALL FROM TREE	Y	N
FALL OFF BICYCLE	Y	N
FALL OFF PLAYGROUND EQUIP	Y	N
SPORTS ACCIDENT	Y	N
CAR ACCIDENT	Y	N
STOMACH PAINS/PROBLEMS	Y	N
SCOLIOSIS	Y	N
BED WETTING	Y	N
HYPERACTIVE/AUTISM	Y	N
LEARNING DIFFICULTY	Y	N
LEG / KNEE / FOOT PAIN	Y	N
DIZZINESS	Y	N
RINGING IN EARS	Y	N
FATIQUE	Y	N
NUMBNESS IN ARMS / HANDS	Y	N
ARM / WRIST / PAIN OR TINGLING	Y	N
SLEEPING PROBLEMS	Y	N
WEIGHT GAIN / LOSS	Y	N
SHOULDER PAIN	Y	N
MEDICATIONS	Y	N
PLAY SPORTS	Y	N
HOSPITAL STAYS	Y	N
ANTIBIOTICS	Y	N
~HOW MANY TIMES		

NOTES

PALPATIONS / SUBLUXATIONS			
L	OCC	R	
L	C1	R	
L	C2	R	
L	C3	R	
L	C4	R	
L	C5	R	
L	C6	R	
L	C7	R	
L	T1	R	
L	T2	R	
L	T3	R	
L	T4	R	
L	T5	R	
L	T6	R	
L	T7	R	
L	T8	R	
L	T9	R	
L	T10	R	
L	T11	R	
L	T12	R	
L	L1	R	
L	L2	R	
L	L3	R	
L	L4	R	
L	L5	R	
L	S1	R	
L	RSL	R	
L	LSI	R	

Dr. Signature_____Date_____

Patient's Name: _____

Gulf Coast Family Chiropractic
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 towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An 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: A state of optimal physical, mental, and social well-being, not merely the absence of 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 to 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 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 expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____have read and fully understand the above statements.

(please print name)

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

I therefore accept chiropractic care on this basis. Signature_____Date:_____

Consent to evaluate and adjust a minor child

I, _____, being the legal parent or legal guardian of _____

(please print your name) (please print child's name)

have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

(signature of Insured / Guardian) (date)

Reviewed By_____Date_____

Patient's Name: _____

Gulf Coast Family Chiropractic
Financial Policies

Insurance Assignment Program

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. We will bill your insurance company as a convenience for you. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time.
2. All deductible amounts must be paid by you in the advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments may also be made.
3. Insurance carriers are billed on weekly cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.
5. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his or her own. The insurance company has 30 days from the billing date to make this decision. Patient payment is expected on fees over 30 days.

Release Of Information And Assignment Of Benefits

The undersigned hereby authorizes this chiropractic provider to release any and all personal information to his/her health insurance company(s), or other physicians or hospitals involved in the treatment of said patient(s), or to any other individuals relative to the health care providers operations. The undersigned does specifically authorize release of said information in accordance with the HIPM Privacy Act. The undersigned authorizes payment directly to the chiropractic provider for all the chiropractic benefits, if any, otherwise payable to the undersigned for the services rendered by said chiropractic provider.

ALL PATIENTS ARE RESPONSIBLE FOR FULL PAYMENT OF ACCOUNTS AT THE TIME SERVICES ARE RENDERED. UNLESS PRIOR ARRANGEMENTS ARE APPROVED.

The undersigned understands that they are fully responsible for all charges associated with their treatment, including their insurance deductible, copayment, and any other services rejected by their insurance company. The undersigned further agrees that in the event that this account is placed for collection, that he/she will be responsible for all collection charges, including a reasonable attorney fee and interest. Outstanding balances will accrue interest at the rate of 1.5% per month.

Patient Name_____

Patient Signature _____ Date: _____

Patient Rep. _____

Patient Rep. Signature _____ Date: _____

Who is Financially responsible for this patient? _____Relationship to Patient:_____

Description of Patient Rep.'s Authority to Act for the Patient (i.e., parent, guardian, etc.) _____

Name:_____DOB:_____ SS # _____

Address:_____

City:_____State:_____Zip:_____

Employer _____

Drivers License # _____ State _____

Reviewed By_____Date_____

Patient's Name:_____

Gulf Coast Family Chiropractic
Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we can supply you with a copy of our privacy policies and procedures. It outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use of dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have been informed that ***I can receive a copy*** of Gulf Coast Family Chiropractic's Notice of Privacy Practices for Protected Health Information if I request it.

Patient Name _____ Date: _____

Patient Signature _____ Staff Member_____

Patient Rep. _____ Patient Rep. Signature_____

Description of Patient Rep.'s Authority to Act for the Patient (i.e., parent, guardian, etc)_____

Gulf Coast Family Chiropractic
Authorization Form

I authorize Gulf Coast Family Chiropractic, LLC to use my name for the following:

Yes No Using my name to thank the person who referred me

Yes No Using my name on the "Welcome as a New Patient" board

This notice is effective as of the date below and expires seven years from the date I last received service in this office.

Patient Name _____ Date ___/ ___ /_____

Patient Signature_____ Staff Member_____

Patient Rep. _____ Patient Rep. Signature_____

Description of Patient Rep.'s Authority to Act for the Patient (i.e., parent, guardian, etc)_____

Reviewed By_____Date_____