

RYAN FAMILY CHIROPRACTIC, INC.

PERSONAL AND FAMILY HEALTH HISTORY

DATE _____

NAME _____ HM PHONE _____ CELL PHONE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

LOCAL ADDRESS _____ CITY _____ STATE _____ ZIP _____

SSN _____ STATUS: S M D W DOB: ____/____/____

HEIGHT _____ WEIGHT _____ PRESENT FAMILY PHYSICIAN _____

OCCUPATION _____ EMPLOYER _____ WK PHONE _____

EMAIL ADDRESS: _____ REFERRED TO OUR OFFICE BY _____

CURRENT HEALTH CONDITION

PURPOSE OF THE APPOINTMENT _____

CONDITION BEGAN _____ JOB RELATED _____ AUTO RELATED _____ OTHER _____

DISABLED FROM WORK: NO ___ YES ___ DATE DISABLED _____

DOCTOR FIRST SEEN _____ OTHER DOCTOR SEEN FOR THIS CONDITION _____

DATE(S): _____ DESCRIBE _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION IN THE LAST YEAR? NO _____ YES _____

DATE & DESCRIPTION OF TREATMENT _____

MEDICATIONS YOU TAKE _____

CHILDREN _____ AGE: _____ AGE: _____ AGE: _____ AGE: _____ AGE: _____

ARE YOU PREGNANT? NO ___ YES ___ YOUR DUE DATE _____

DO YOU HAVE A PACE MAKER? YES / NO

OTHER SYMPTOMS

- HEADACHES
- NECK PAIN
- SLEEPING PROBLEMS
- BACK PAIN
- NERVOUSNESS
- TENSION
- IRRITABILITY
- CHEST PAINS
- DIZZINESS
- FACE FLUSHED
- NECK STIFF

- PINS & NEEDLES IN LEGS
- PINS & NEEDLES IN ARMS
- NUMBNESS IN FINGERS
- NUMBNESS IN TOES
- SHORTNESS OF BREATH
- FATIGUE
- DEPRESSION
- LIGHT BOTHERS EYES
- LOSS OF MEMORY
- EARS RING
- FEVER

- FAINTING
- COLD SWEATS
- LOSS OF SMELL
- LOSS OF TASTE
- DIARRHEA
- FEET COLD
- HANDS COLD
- STOMACH UPSET
- CONSTIPATION
- LOSS OF BALANCE
- BUZZING IN EAR

PAST HEALTH HISTORY

MAJOR SURGERY OR OPERATIONS – DATE & DESCRIBE

MAJOR ACCIDENTS OR FALLS – DATE & DESCRIBE

FRACTURES OR DISLOCATIONS – DATE & DESCRIBE

KNOCKED UNCONSCIOUS OR STUNNED – DATE & DESCRIBE

HOSPITALIZATION (other than above)

HAVE YOU SEEN A CHIROPRACTOR BEFORE?: NO ___ YES ___ DOCTORS NAME _____

DATE & DESCRIBE YOUR PREVIOUS EXPERIENCE _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> APPENDICITIS	<input type="checkbox"/> MEASLES	<input type="checkbox"/> INFLUENZA
<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> MUMPS	<input type="checkbox"/> PLEURISY
<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> POLIO
<input type="checkbox"/> SUBSTANCE ABUSE	<input type="checkbox"/> DIABETES	<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> CANCER	<input type="checkbox"/> EPILEPSY
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> MENTAL ILLNESS
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> STROKE	<input type="checkbox"/> LUPUS	<input type="checkbox"/> HEMOPHILIA

HABITS

DO YOU SMOKE OR USE TOBACCO: NO _____ YES _____ ALCOHOL: NO _____ YES _____

DO YOU DRINK COFFEE OR OTHER CAFFIENATED DRINKS: NO _____ YES _____

HOURS OF SLEEP IN AN AVERAGE NIGHT _____ HOW OLD IS YOUR MATTRESS _____

DAILY HIGH STRESS: NO _____ YES _____ HAVE YOU HAD A NERVOUS BREAKDOWN: NO _____ YES _____

DO YOU EXERCISE ON A REGULAR BASIS: NO _____ YES _____ FREQUENCY _____

UPON THE COMPLETION OF YOUR FIRST VISIT, YOU WILL RECEIVE A CHIROPRACTIC REPORT TO DISCUSS THE DIFFERENT TYPES OF ACTIVE LIFE PLANS THAT ARE AVAILABLE TO YOU. CHIROPRACTIC ACTIVE LIFE PLANS ARE DESIGNED TO HELP GET YOU FEELING BETTER QUICKLY AND TO HELP YOU AND YOUR FAMILY BE AS HEALTHY AS POSSIBLE. PLEASE REVIEW THE EXPLANATIONS OF THE CHIROPRACTIC ACTIVE LIFE PLANS PRIOR TO YOUR CHIROPRACTIC REPORT APPOINTMENT SO YOU CAN CHOOSE THE LEVEL OF PARTICIPATION THAT SUPPORTS YOU IN REACHING ALL OF YOUR HEALTH GOALS.

AS A RESULT OF MY CHIROPRACTIC CARE, I WOULD LIKE TO
PLEASE CHECK ALL THAT APPLY

- FEEL BETTER QUICKLY
- HAVE A HEALTHIER SPINE
- HAVE A HEALTHIER BODY BY KEEPING MY NERVE SYSTEM HEALTHY
- LIVE A HEALTHIER LIFESTYLE

RYAN FAMILY CHIROPRACTIC, INC.

303 Donehoo St.

Statesboro, Ga. 30458

(912) 489-5559 or Fax (912) 489-3028

Authorization and Assignment of Benefits

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Ryan Family Chiropractic, Inc. will prepare any necessary reports and forms so that any amount authorized to be paid will be paid directly to the Ryan Family Chiropractic, Inc. and will be credited to my account on receipt. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services provided to me will be immediately due and payable in full.

I am aware that Ryan Family Chiropractic will not file claims to secondary insurance carriers. In the event that I have a secondary insurance carrier, I may request Ryan Family Chiropractic to prepare any necessary reports and forms to assist me in making collection directly from the insurance company. I understand that I will be responsible for the original amount due to Ryan Family Chiropractic in full regardless of insurance coverage.

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Ryan Family Chiropractic for all covered medical services provided to me during all course of treatment and care. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated or cared for by Ryan Family Chiropractic, and will constitute a continuing authorization, maintained on file with Ryan Family Chiropractic which will authorize and allow for direct payment to Ryan Family Chiropractic of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services and care.

I hereby agree that if my bill has to be turned over to a third party collection agency for non-payment, there will be a collection fee added to my bill of 33%. This is pursuant to Georgia Statutory Law "O.C.G.A.-13-1-11".

I hereby authorize Dr. Jason Ryan to treat my condition as he deems appropriate.

Patient's Signature

Date

Consent to Treat a Minor

Date

Guardian or Spouse's
Signature of Authorizing Care

Date

RYAN FAMILY CHIROPRACTIC, INC.

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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 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 able 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 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 to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area.

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.

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