FAMILY CHIROPRACTIC PLUS

Dr. Joy McClenny, D.C.
1635 N Howe Street Ste J& K, Southport, NC 28461
910-454-4041 / Fax: 910-454-4044
www.familychiropracticplus.com

NEW PATIENT INFORMATION

Name:		Date:
Address:	City/State/ZIP:	
Home Phone:	Work Phone:	Cell Phone:
Birth Date:	Age:	Social Security #:
Marital Status: ❑ M ❑ D ❑ S ❑ W		Email:
Your Employer:		Occupation:
Spouse's Name:		Spouse's Employer:
Children's Names and Ages:		
Favorite Hobbies or Interests:		
Method of Payment for First Visit:	Cash Check	Credit Card

Reasons for consulting our office: (please check all that apply)

- ❑ Headaches
- ❑ Sinus Problems
- ❑ Difficulty sleeping
- ❑ Indigestion
- ❑ Neck Pain
- ❑ Back Pain
- ❑ Arm or Leg Pain
- ❑ Low Energy
- ❑ Low Immune function
- ❑ Ears Ringing
- ❑ Eye Problems
- ❑ Allergies
- ❑ Asthma
- ❑ Numbness in Leg
- ❑ Numbness in Arm
- ❑ Heartburn
- ❑ Fibromyalgia or MS
- ❑ Wellness
- ❑ Other: _____

Have you ever seen a Chiropractor before? _____
Who may we thank for referring you?_____
Have you had same or similar problem(s) before? _____
If so, for how long? _____
Is this the result of an auto or work injury?_____ If so, when?_____
Father, mother, brother, sister, children with similar problems?_____ If so, who?_____
Other doctors you have seen for this problem?_____
Surgeries you have had: _____
Medications you currently take: _____
Is there any chance you are pregnant?_____
Have you ever been diagnosed with cancer?_____ If so, what kind? _____

Do you have health insurance?_____ Name of Company:_____

The above information is true and accurate to the best of my knowledge. **I Clearly Understand and Agree that All Services Rendered to Me are Charged Directly to Me and that I Am Directly Responsible for Payment.**

Patient or Guardian Signature:_____ Date:_____

Vertebral Subluxations Can Cause Pain

1. Which pain or condition you have checked is the worst?

   _____
   _____

2. How long has it bothered you?

   _____
   _____

3. Vertebral Subluxations can cause irritation to different fibers within nerves. Is your pain sharp or dull?

   _____
   _____

4. Subluxations can put pressure on the spinal cord which can be constant or occasional. Is your pain constant or occasional?

   _____
   _____

5. Pressure on the spinal cord or nerves can be worse in the AM or PM. Which one is harder for you?

   _____
   _____

6. Does this pain radiate into an extremity or stay in one area?

   _____
   _____

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 or condition other than vertebral subluxation. 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 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.
(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 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 that Dr. McClenny has 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 period: _____

_____ _____
(Signature) (Date)

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

- We may need to use your health information within our practice for quality control or other operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature/ Date Date

Chiropractic Pediatric Health Screening

1635 N Howe Street, Suite J & K
Southport, NC 28461
(910)-454-4041
(910)-454-4044 Fax

Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stress (Physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

Child's Name:_____ **Birthday:**_____

Parent's Name:_____ **Address:**_____

_____

Phone: _____ **Email:**_____

1. **Is your child currently benefiting from chiropractic care? Yes No When was their last visit?**_____

2. **Circle Appropriately**

   Birth Place: Home / Hospital /Birth Center
   Type: Vaginal / C-Section
   Procedures: Forceps / Vacuum Extraction

3. **Circle Appropriately**

   Which contact sports does your child participate in?
   Soccer / Football / Gymnastics / Karate / Hockey
   Basketball / Dance / Other_____

4. **According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this ever happened to your child?**
   Yes No

5. **Check any of the following conditions your child has suffered from during the past six months:**
   □ Ear Infections □ Scoliosis □ Seizures □ Chronic Colds □ Headaches

   □ Asthma/Allergies □ Digestive Problems □ ADHD □ Recurring Fevers □ Growing or Back Pains

   □ Colic □ Bed Wetting □ Car Accident □Temper Tantrums □ Other _____

6. **How many prescriptions of antibiotics has your child taken?**

   During the past 6 months _____ Total during His/her Lifetime _____

7. **How many other prescription medications has your child taken?**

   During the past 6 months _____ Total during His/her Lifetime _____

A brief non-invasive spinal health screening will be performed to determine if your child has any functional or structural spinal problems. Spinal misalignments at an early age can cause nervous system stress (Vertebral Subluxation complex) that can interfere with your child's optimum health and immune function. Chiropractic care helps your child's growing spine and improves their health naturally.

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(Signature) (Date)

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Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature/ Date Date

Family Chiropractic Plus

Rob McClenny
1653 N Howe Street Suites J & K, Southport NC 28461
910-454-4041 / Fax: 910-454-4044

NEW PATIENT INFORMATION

Name:			Date:
Address:			
Home Phone:		Work Phone:	Cell Phone:
Birth Date:	Age:		Social Security #:
Sex: M/F	Height:	Weight:	
Occupation:			Employer:
Email:			
Favorite Hobbies or Interest:			
Method of Payment:	Cash	Check	Credit Card
Referred By:			

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____
Chief complaint (reason you are here):_____
_____
Previous treatments for this complaint:_____
_____
Other complaints or problems:_____
_____
Current medications/drugs (prescription or over the counter)_____
_____
Are you currently under the care of a physician or other health care professional? (If yes, please give name and date of last visit):_____
Nutritional supplements you are taking:_____
Do you smoke, drink coffee or alcohol? (If yes, indicate how much)
Cigarettes_____ Coffee_____ Alcohol_____
List any major illnesses with approximate dates:_____
_____
List any surgery or operations with approximate dates:_____
_____
Past Accidents or Injuries:_____
_____
Any family history of serious illnesses such as Cancer, Diabetes, Heart or other?_____
_____
For women only, is there any chance you are pregnant? _____
Marital Status: S M D W Name of Spouse: _____ Health of Spouse: _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any household pets or other animals you or family members are in close contact with you?_____
_____
What can we do to make you happy?_____

Signature_____ Date:_____