Ribellia
FAMILY CHIROPRACTIC

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Name _____ Referred By _____

Address _____ Social Security # _____

City _____ State _____ Zip _____ Employer _____

Phone: (Home) _____ (cell) _____ Marital Status S M D W

(Work)_____ Spouse's Name _____

E-mail _____ Spouse's Occupation _____

Date of Birth _____ (Age _____) Number of children_____

OFFICE PROCEDURES AGREEMENT

- RIBELLIA FAMILY CHIROPRACTIC WILL TAKE EVERY MEANS NECESSARY TO PROTECT MY PHI (protected health Information)
- RIBELLIA FAMILY CHIROPRACTIC HAS THE RIGHT TO TRANSFER ANY HEALTH RECORDS, VIA US MAIL, IF A WRITTEN REQUEST IS MADE BY THE PATIENT.
- RIBELLIA FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND ME APPOINTMENT REMINDERS AND/OR MISSED APPOINTMENT CORRESPONDENCE BY PHONE OR VIA US MAIL OR OTHER SIMILAR METHODS.
- RIBELLIA FAMILY CHIROPRACTIC HAS MY PERMISSION TO LEAVE PHONE MESSAGES OR VERBAL MESSAGES WITH WHOEVER ANSWERS THE PROVIDED PHONE NUMBERS REGARDING APPOINTMENT INFORMATION.
- I UNDERSTAND THAT PERSONAL HEALTH INFORMATION WILL ONLY BE SHARED BY PHONE WITH ME AS THE PATIENT OR TO LEGAL GAURDIANS IF THE PATIENT IS A MINOR.
- RIBELLIA FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND NEWSLETTERS OR OTHER PRINTED MATERIAL TO ME VIA US MAIL OR OTHER SIMILAR METHODS. TO BE REMOVED FROM THIS LIST, I MAY REQUEST TO BE RELEASED AS AN ACTIVE PATIENT.
- I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST THAT RIBELLIA FAMILY CHIROPRACTIC RESTRICT HOW MY PHI IS USED AND/OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. HOWEVER, THE PRACTICE IS NOT REQUIRED TO AGREE TO ANY RESTRICTIONS THAT I HAVE REQUESTED. IF THE PRACTICE AGREES TO A REQUESTED RESTRICTION, THEN THE RESTRICTION IS BINDING ON THE PRACTICE.
- I UNDERSTAND THAT IF I DO NOT SIGN THIS CONSENT OR IF I REVOKE IT AT ANY TIME, RIBELLIA FAMILY CHIROPRACTIC HAS THE RIGHT TO REFUSE TO TREAT ME.
- WHEN SIGNING THE DAILY SIGN UP SHEET AT THE FRONT DESK, I UNDERSTAND THAT MY SIGNATURE WILL BE SEEN BY OTHER PATIENTS OF RIBELLIA FAMILY CHIROPRACIC.
- I UNDERSTAND AND CONSENT TO RIBELLIA FAMILY CHIROPRACTIC USING MY CHIROPRACTIC STORY AS A TESTIMONIAL IN THEIR TESTIMONIAL BOOKS THAT ARE USED IN THE OFFICE. (SEPARATE SIGNATURE IS ALSO REQUIRED FOR THIS.)
- I CONSENT TO RIBELLIA FAMILY CHIROPRACTIC USING MY PICTURE ON THEIR WALL (APPLIES TO CHILDREN ONLY)
-

BY SIGNING BELOW, HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO ANY INSURANCE COMPANY, ATTORNEY, OR ADJUSTER FOR THE PURPOSE OF CLAIM REIMBURSEMENT OF CHARGES INCURRED BY ME. I GRANT THE USE OF MY SIGNED STATEMENT OF AUTHORIZATION WITH MY SIGNATURE FOR REQUIRED INSURANCE SUBMISSIONS. I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME WILL BE CHARGED TO ME, AND I'M RESPONSIBLE FOR TIMELY PAYMENT OF SUCH SERVICES. I UNDERSTAND AND AGREE THAT HEALTH/ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND THAT FEES FOR PROFESSIONAL SERVICES WILL BECOME IMMEDIATELY DUE UPON SUSPENSION OR TERMINATION OF MY CARE OR TREATMENT.

_____ _____ _____

Printed Patient Name Signature (guardian if minor) Date

ELECTRONIC NEWSLETTERS OR OTHER ELECTRONIC MATERIAL MAY BE SENT TO MY E-MAIL ADDRESS(S).
_____ YES _____ NO _____ INITIALS

Name _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that Apply

1. Was Your Birth Traumatic?

Long Delivery?	Y
Difficult Delivery?	Y
Forceps?	Y
Caesarian?	Y
Breach/cephalic?	Y
Home birth?	Y
Drugs during delivery	Y
Induced Labor?	Y

2. Growth and Development

Care for your spine?	Y
Fall out of bed?	Y
Bang your head?	Y
Breastfed?	Y
Childhood sickness?	Y
Have any Accidents?	Y
Have Surgery?	Y
Take Drugs?	Y
Fall while learning to walk?	Y
Bullied by your siblings?	Y
Child abuse	Y
Spanking?	Y
Pulled ear/chin	Y
Chair pulled out when sitting?	Y
Fall down the stairs?	Y
Pulled by your arm?	Y
Experience other traumas?	Y

3. Current Health Habits

Did/do you	
Use Tobacco?	Y
Drink alcohol	Y
Eat healthy foods	Y
Have any accidents?	Y
Have you had surgery	Y
Take drugs?	Y
Have Teeth Problems?	Y
Have Eye Problems?	Y
Have Hearing Problems?	Y
Exercise regularly?	Y
Have sleeping problems?	Y
Have occupational stress?	Y
Have physical stress?	Y
Have mental stress?	Y
Have sports injuries?	Y
Sleeping posture	
– side– stomach – back	

Current Health Situation

Reason for Your Visit Today_____

_____

Date your situation started _____

Pains are Sharp Dull Constant Intermittent

What activities aggravate your situation/pain?

_____

What activities lessen your situation/pain?

_____

Is your situation worse during certain times of the day?

_____

Is your situation getting progressively worse?

_____

Other Doctors seen for this situation _____

Any home remedies? _____

What medications are you taking?_____ _____

Use an 'X' to mark your complaints areas on the diagram

What side effects have you experienced from the drugs and surgery? _____

Please mark below whether you have or have had any of the following conditions/illnesses:

- ✕ Allergies
- ✕ Hay Fever
- ✕ Fatigue or Weakness
- ✕ Night Sweats
- ✕ Weight Loss
- ✕ Weight Gain
- ✕ Sleeping Problems
- ✕ Skin Problems
- ✕ Loss of Balance
- ✕ Dizziness
- ✕ Vertigo
- ✕ Fainting
- ✕ Headaches
- ✕ Seizures
- ✕ Loss of Memory
- ✕ Vision Trouble
- ✕ Hearing Trouble
- ✕ Ear Infections
- ✕ Ringing in Ears
- ✕ Loss of Smell
- ✕ Loss of Taste
- ✕ Difficulty Swallowing
- ✕ Difficulty Speaking
- ✕ Sinus Trouble
- ✕ Asthma
- ✕ Wheezing
- ✕ Chronic Cough
- ✕ Shortness of Breath
- ✕ Chest Pain or Pressure
- ✕ Heart Trouble
- ✕ High Blood Pressure
- ✕ Low Blood Pressure
- ✕ Cold Hands or Feet
- ✕ Abdominal Pain
- ✕ Indigestion
- ✕ Excess Gas
- ✕ Heartburn
- ✕ Constipation
- ✕ Diarrhea
- ✕ Nausea or Vomiting
- ✕ Bedwetting
- ✕ Urinary Pain /Frequency
- ✕ Kidney /Bladder Trouble
- ✕ Blood in Urine or Stool
- ✕ Menstrual Problems/Pain
- ✕ Prostate Trouble
- ✕ Erectile Dysfunction
- ✕ Fertility Problems
- ✕ Excessive Thirst
- ✕ Thyroid Trouble
- ✕ Anxiety /Nervousness
- ✕ Mood Swings
- ✕ Depression
- ✕ Arthritis
- ✕ Bone Fracture
- ✕ Dislocated Joints
- ✕ Autoimmune Disease
- ✕ Cancer
- ✕ Diabetes
- ✕ Fibromyalgia
- ✕ Multiple Sclerosis
- ✕ Rheumatic Fever
- ✕ Tuberculosis
- ✕ Other:_____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side					_____
Mother's Side					_____

Please indicate which activities of daily living are compromised by your current state of health:

General:

- Walking
- Sitting
- Climbing stairs
- Chewing
- Kneeling
- Sleeping
- Standing
- Lifting children
- Reading
- Swimming
- Playing instruments
- Using telephone
- Running
- Bending
- Lying in bed
- Using keyboard
- Exercising
- Sitting in recliner
- Recreational activities
- Sewing or crafts
- Driving a car
- Riding in a car
- Getting into/out of a car

Housework:

- Doing laundry
- Making beds
- Vacuuming
- Washing dishes
- Ironing
- Carrying groceries
- Caring for pets
- Cooking

Yard work:

- Mowing lawn
- Raking leaves
- Gardening
- Shoveling snow

Personal grooming:

- Combing hair
- Shaving
- In/out of bathtub
- Brushing teeth

Your goal*:*

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

Wellness Commitment

At Ribellia Family Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this; we need to understand your commitment toward being healthy. We do ask for your *cooperative commitment*.

Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%--------20%--------30%--------40%--------50%--------60%--------70%--------80%--------90%--------100%

_____ _____

Signature Date