

MAYSVILLE  
1335 South Gate Plaza  
Maysville, KY 41056  
606-564-4213  
800-571-1117  
Fax: 606-564-4406

GEORGETOWN  
100 Eastside Drive  
Georgetown, KY 40324  
502-868-0097  
800-869-0714  
Fax: 502-868-7499

CYNTHIANA  
1050 US Hwy 27 South  
Cynthiana, KY 41031  
859-234-1605  
866-789-1605  
Fax: 859-234-1628

## REPORT OF HISTORY

**VITAL HISTORY:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Your Social Security Number \_\_\_\_\_ Birthdate: \_\_\_\_\_

Spouse Social Security Number \_\_\_\_\_ Birthdate: \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Age \_\_\_\_\_ Number of Children \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employed by \_\_\_\_\_ Phone: \_\_\_\_\_

Last Physician \_\_\_\_\_ Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Primary Health Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Auto Insurance: \_\_\_\_\_

**ACCIDENT-INJURY INFORMATION:** Date of Accident \_\_\_\_\_ Time \_\_\_\_\_

Accident location: Home \_\_\_\_\_ Work \_\_\_\_\_ Auto \_\_\_\_\_ Elsewhere \_\_\_\_\_

Was Police Report Made \_\_\_\_\_ Employer notified \_\_\_\_\_ Worker's Comp \$ \_\_\_\_\_

Have you been placed on disability: \_\_\_\_\_

Dates of disability: \_\_\_\_\_

Description of accident: \_\_\_\_\_

**PREVIOUS TREATMENT:** \_\_\_\_\_ DC \_\_\_\_\_ MD \_\_\_\_\_ Results \_\_\_\_\_

Diagnosis and type of treatment \_\_\_\_\_

**HEALTH HISTORY:** List drugs you are now taking \_\_\_\_\_

Do you have TB \_\_\_\_\_ VD \_\_\_\_\_ In the Past \_\_\_\_\_ Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_

Other \_\_\_\_\_

Surgery History \_\_\_\_\_ Appendix \_\_\_\_\_ Tonsils \_\_\_\_\_ Hernia \_\_\_\_\_ Hemorrhoid \_\_\_\_\_ Spinal \_\_\_\_\_

\_\_\_\_\_ Hysterectomy \_\_\_\_\_ Prostate \_\_\_\_\_ Cyst \_\_\_\_\_ Cancer \_\_\_\_\_ List Others \_\_\_\_\_

List Fractures/Dislocations/Concussions \_\_\_\_\_

\*List Previous Accidents/Injuries/Major Illnesses \_\_\_\_\_

**INSURANCE PATIENTS**

Our office does not guarantee that your insurance will pay. We will make every effort, at the beginning of your health care, to receive verification of your policy and it's benefits. However, if for some reason, your insurance claim is denied, you are responsible for the full amount of your bill.

I Authorize the Release of any Medical Information Necessary to Process the Claim. If my current policy prohibits direct payment to the doctor, then I herby also instruct and direct you to make out the checks to me and mail it as follows:

**MAYSVILLE**  
1335 South Gate Plaza  
Maysville, KY 41056  
606-564-4213  
800-571-1117  
Fax: 606-564-4406

**GEORGETOWN**  
100 Eastside Drive  
Georgetown, KY 40324  
502-868-0097  
800-869-0714  
Fax: 502-868-7499

**CYNTHIANA**  
1050 US Hwy 27 South  
Cynthiana, KY 41031  
859-234-1605  
866-789-1605  
Fax: 859-234-1628

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THEM FOR SERVICES RENDERED.

SIGNED (Insured or Authorized Person) \_\_\_\_\_ Date: \_\_\_\_\_

**Consent To Treatment of Minor Child**

I hereby authorize Dr. \_\_\_\_\_  
and whomever he may designate as his assistants to administer  
**DATE:** \_\_\_\_\_  
chiropractic care as they deem necessary to my \_\_\_\_\_  
\_\_\_\_\_ (indicate relationship of child).  
this

**Name** \_\_\_\_\_  
there  
**Date at** \_\_\_\_\_, \_\_\_\_\_  
at  
\_\_\_\_\_ city \_\_\_\_\_ state  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_  
**Signed:** \_\_\_\_\_  
Parent of Guardian

**Witnessed:** \_\_\_\_\_

**PREGNANCY RELEASE**

I, \_\_\_\_\_, in signing  
form, state to the best of my knowledge  
is no pregnancy (confirmed or suspected)  
the time this service was rendered.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Witness

## **SYMPTOM QUESTIONNAIRE**

*This information will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. The doctor will go over the questions with you when completed.*

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Where are you having your major problems?     Head     Lower Back     Between Shoulder Blades     Other:  
 Neck     Shoulder     Hip

How long has this condition lasted?  
\_\_\_\_\_

Is this condition:     Getting worse     The Same     Improving     Other:  
\_\_\_\_\_

Briefly describe initial cause of condition (injury, accident, etc.): \_\_\_\_\_  
\_\_\_\_\_

Pain came on:     Gradually     Suddenly    The pain is:     Occasional     Frequent     Constant

Describe the pain:     Sharp (*like a knife sticking you*)     Dull (*like a toothache*)     Burning (*hot*)  
\_\_\_\_\_

Does the pain:     Stay in one spot     Radiate (*travel or shoot*)     Go up down the spine  
\_\_\_\_\_

What time of day is pain the worst?     Morning     Afternoon     Evening     Night     All the time  
\_\_\_\_\_

Do you have pain in:     Legs     Feet     Arms     Hands     Left     Right     Other:  
\_\_\_\_\_

Do you have numbness, tingling or pins and needles in:     Legs     Feet     Arms     Hands     Left     Right     Other:  
\_\_\_\_\_

What makes the pain worse?  
\_\_\_\_\_

What makes the pain better?  
\_\_\_\_\_

Does the pain affect your sleeping?     No     Occasionally     Frequently     Constantly  
\_\_\_\_\_

Does the pain affect your work?     No     Occasionally     Frequently     Constantly  
\_\_\_\_\_

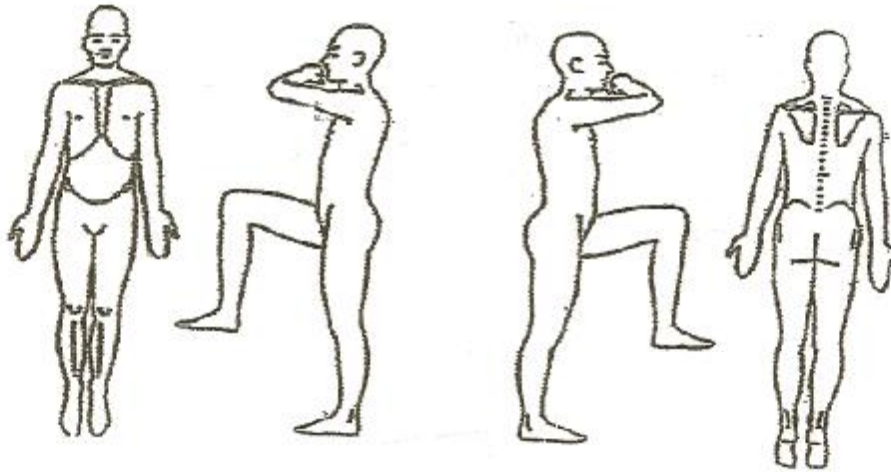
Have you been hospitalized in the last 5 years?     No     Yes > If yes, for what?  
\_\_\_\_\_

Have you had major surgery in the last 5 years?     No     Yes > If yes, what surgery?  
\_\_\_\_\_

Have you seen other doctors for this condition?     No     Yes > If yes, doctor's name  
\_\_\_\_\_

Have you ever seen a chiropractor before?     No     Yes > If yes, doctor's name  
\_\_\_\_\_

**PLEASE INDICATE PROBLEM AREAS WITH X'S**



---

I hereby certify that the aforementioned enclosed information is true and answered correctly. I give my consent for examination, x-rays and treatment at the office of Family Chiropractic. I agree that if they feel it necessary to have my X-ray's read by an outside radiologist and my insurer fails too, I will accept full responsibility for payment.

I understand that I am responsible for payment to Family Chiropractic, and that I will be responsible for any and all collection costs in addition to my bill, that may arise, including collection fees, court costs, and reasonable attorney's fees, should collection action be taken on this bill. Accounts 90 days past due are subject to an interest rate of 1½% per month on the unpaid balance. I hereby release and forever discharge the aforesaid Doctor of Chiropractic from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment.

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

WITNESS \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*NOTICE\*\*\***

**THIS OFFICE RESERVES THE RIGHT TO CHARGE AN 18% APR INTEREST RATE TO ANY ACCOUNT MORE THAN 90 DAYS PAST DUE.**

**\*\*\* IN ALL CASES FAMILY CHIROPRACTIC REFERS TO THE OFFICE OF TREATMENT.**