HIPAA Compliance *Patient Consent Form*

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign and return to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care.
2. Inadvertent disclosures – open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes – to process a claim or aid in investigation.
5. Emergency – in the event of a medical emergency we may notify a family member.
6. For Public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please contact our office. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I have received a copy of Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

May we discuss your medical condition with any member of your family? ◯Yes ◯No

If yes, please name family members allowed: _____

This consent was signed by: _____ Signature: _____ Date: _____

Emergency Contact: _____ Phone Number: _____

Informed Consent for Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THIS OFFICE TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient Name: _____ Signature: _____ Date: _____

Guardian Signature (for minor): _____ Relationship to Patient: _____

☐ In addition, I give my permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Adult Patient Questionnaire

Confidential Patient Information

First Name:	Last Name:	Date:
SSN:	DOB:	Sex:
Occupation:	# of Children:	Marital Status:
Street Address:		Height:
City, State, Postal Code:		Weight:
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emergency Relation:	Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit?

Are you receiving care from any other health professionals? ○ Yes ○ No
– If yes, please name them and their specialty:

Please note any significant family medical history:

Current Health Conditions

What health condition(s) bring you into our office?

Have you received care for this problem before? ○ Yes ○ No
– If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

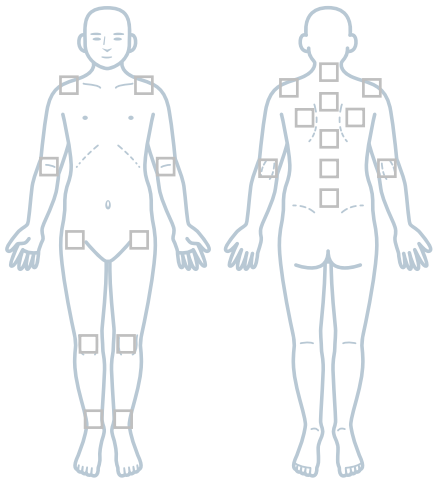
Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.

X = Current condition; O = Past condition



Your Health Goals

What are your top three health goals?

1. _____

2. _____

3. _____

Chiropractic History

What would you like to gain from chiropractic care? ○ Resolve existing condition(s) ○ Overall wellness ○ Both

Have you ever visited a chiropractor? ○ Yes ○ No – If yes, what is their name?

– What is their specialty? ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ Subluxation-based ○ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ○ Yes ○ No

– If yes, please explain:

Notable childhood injuries? ○ Yes ○ No – If yes, please explain:

Youth or college sports? ○ Yes ○ No – If yes, list major injuries:

Any past auto accidents? ○ Yes ○ No – If yes, please explain:

How often do you exercise? ○ None ○ 1-3x per week ○ 4-6x per week ○ Daily

– What types of exercise?

How do you normally sleep? ○ Back ○ Side ○ Stomach Do you wake up: ○ Refreshed and ready ○ Stiff and tired

Do you commute to work? ○ Yes ○ No – If yes, how many minutes per day?

List any problems with flexibility (*ex. putting on shoes/socks, etc*):

How many hours per day do you typically spend sitting at a desk? On a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*			*None*		*Moderate*		*High*
Alcohol	1	2	3	4	5		Processed Foods	1	2	3	4	5
Water	1	2	3	4	5		Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5		Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5		Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5		Recreational Drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs or other that you are taking and why:

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*			*None*		*Moderate*		*High*
Home	1	2	3	4	5		Money	1	2	3	4	5
Work	1	2	3	4	5		Health	1	2	3	4	5
Life	1	2	3	4	5		Family	1	2	3	4	5

Acknowledgement & Consent

Patient Signature: _____ Date: _____

Flack Family Chiropractic

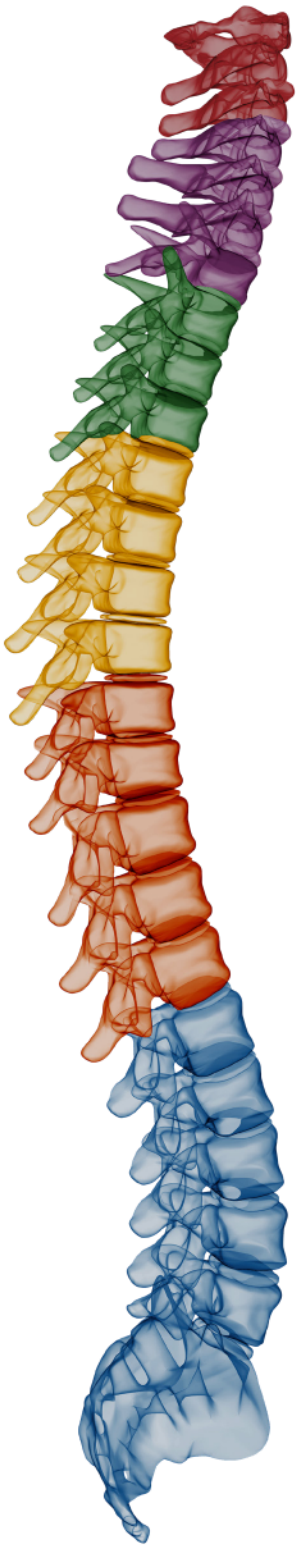
4246 Washington Road Suite 6, Evans, GA | 706-305-3241 | Fax: 706-922-7795

FlackFamilyChiropractic@gmail.com | www.FlackFamilyChiropractic.com

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	
		☐	☐	Ear & Sinus Infections	
		☐	☐	Allergies & Congestion	
		☐	☐	Immune Deficiency	
		☐	☐	Headaches & Migraines	
		☐	☐	Vertigo & Dizziness	
		☐	☐	Sore Throat & Strep	
		☐	☐	Swollen Tonsils & Adenoids	
		☐	☐	Vision & Hearing Issues	
		☐	☐	Low Energy & Fatigue	
		☐	☐	Difficulty Sleeping	
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	
		☐	☐	Epilepsy & Seizures	
		☐	☐	Sensory & Spectrum	
		☐	☐	ADD / ADHD	
		☐	☐	Focus & Memory Issues	
		☐	☐	Anxiety & Stress	
		☐	☐	Balance & Coordination	
		☐	☐	Speech Issues	
		☐	☐	TMJ / Jaw Pain	
		☐	☐	Stiff Neck & Shoulders	
		☐	☐	Depression	
		☐	☐	High Blood Pressure	
		☐	☐	Poor Metabolism & Weight Control	
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	
		☐	☐	Chronic Colds & Cough	
		☐	☐	Asthma	
		☐	☐	Bronchitis & Pneumonia	
		☐	☐	Functional Heart Conditions	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	
		☐	☐	Jaundice	
		☐	☐	Fever	
		☐	☐	Indigestion & Heartburn	
		☐	☐	Stomach Pains & Ulcers	
		☐	☐	Blood Sugar Problems	
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	
		☐	☐	Hyperactivity	
		☐	☐	Chronic Fatigue	
		☐	☐	Chronic Stress	
		☐	☐	Allergies & Eczema	
		☐	☐	Skin Conditions / Rash	
		☐	☐	Kidney Problems	
		☐	☐	Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	
		☐	☐	Chrohn's, Colitis & IBS	
		☐	☐	Diarrhea	
		☐	☐	Bed-wetting	
		☐	☐	Bladder & Urination Issues	
		☐	☐	Cramps & Menstrual Issues	
		☐	☐	Cysts & Endometriosis	
		☐	☐	Infertility	
		☐	☐	Impotency	
		☐	☐	Hemorrhoids	
		☐	☐	Sciatica & Radiating Pain	
		☐	☐	Lumbopelvic / SI Joint Pain	
		☐	☐	Hamstring Tightness	
		☐	☐	Disc Degeneration	
		☐	☐	Leg Weakness & Cramps	
		☐	☐	Poor Circulation & Cold Feet	
		☐	☐	Knee, Ankle & Foot Pain	
		☐	☐	Weak Ankles & Arches	
		☐	☐	Lower Back Pain	
		☐	☐	Gluten & Casein Intolerance	

Patient Name: _____ Date: _____

Adult Patient Questionnaire

Confidential Patient Information

First Name:	Last Name:	Date:
SSN:	DOB:	Sex:
Occupation:	# of Children:	Marital Status:
Street Address:		Height:
City, State, Postal Code:		Weight:
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emergency Relation:	Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit?

Are you receiving care from any other health professionals? ○ Yes ○ No
– If yes, please name them and their specialty:

Please note any significant family medical history:

Current Health Conditions

What health condition(s) bring you into our office?

Have you received care for this problem before? ○ Yes ○ No
– If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

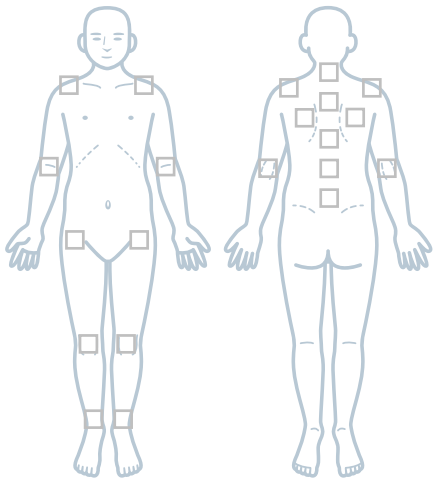
Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.

X = Current condition; O = Past condition



Your Health Goals

What are your top three health goals?

1. _____

2. _____

3. _____

Chiropractic History

What would you like to gain from chiropractic care? ○ Resolve existing condition(s) ○ Overall wellness ○ Both

Have you ever visited a chiropractor? ○ Yes ○ No – If yes, what is their name?

– What is their specialty? ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ Subluxation-based ○ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ○ Yes ○ No

– If yes, please explain:

Notable childhood injuries? ○ Yes ○ No – If yes, please explain:

Youth or college sports? ○ Yes ○ No – If yes, list major injuries:

Any past auto accidents? ○ Yes ○ No – If yes, please explain:

How often do you exercise? ○ None ○ 1-3x per week ○ 4-6x per week ○ Daily

– What types of exercise?

How do you normally sleep? ○ Back ○ Side ○ Stomach Do you wake up: ○ Refreshed and ready ○ Stiff and tired

Do you commute to work? ○ Yes ○ No – If yes, how many minutes per day?

List any problems with flexibility (*ex. putting on shoes/socks, etc*):

How many hours per day do you typically spend sitting at a desk? On a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*			*None*		*Moderate*		*High*
Alcohol	1	2	3	4	5	Processed Foods		1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners		1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks		1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes		1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs		1	2	3	4	5

Please list any drugs/medications/vitamins/herbs or other that you are taking and why:

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*			*None*		*Moderate*		*High*
Home	1	2	3	4	5	Money		1	2	3	4	5
Work	1	2	3	4	5	Health		1	2	3	4	5
Life	1	2	3	4	5	Family		1	2	3	4	5

Acknowledgement & Consent

Patient Signature: _____ Date: _____

Flack Family Chiropractic

4246 Washington Road Suite 6, Evans, GA | 706-305-3241 | Fax: 706-922-7795

FlackFamilyChiropractic@gmail.com | www.FlackFamilyChiropractic.com

Pregnancy Questionnaire

Patient Name: _____ Date: _____

Previous Birth Experience

Is this your first pregnancy? ○ Yes ○ No

– If not, please tell us about your previous pregnancy and/or birth experience(s):

Do you plan to follow the same plan as your previous delivery? ○ Yes ○ No

– If not, what would you like to change?

Conception & Early Pregnancy

When is your expected calculated due date?

Did you have any difficulty conceiving? ○ Yes ○ No

– If yes, please explain:

Have you ever used any form of hormonal or oral contraceptives? ○ Yes ○ No

– If yes, which ones, and for how long?

When was your last menstrual cycle?

What was your pre-pregnancy weight? – Current Weight?

Have you experienced morning sickness? ○ Yes ○ No

– If yes, please explain:

Current Health Conditions

What type of exercise(s) are you currently performing?

Please tell us about your current diet, and any dietary restrictions.

Have you taken any medications or supplements during your pregnancy? ○ Yes ○ No

– If yes, please explain:

Have you had any slips, falls, or other physical traumas during the pregnancy? ○ Yes ○ No

– If yes, please explain:

Have you had any major emotional stressors during your pregnancy? ○ Yes ○ No

– If yes, please explain:

Your Birth Plan

What are your top three goals for this pregnancy?

1. _____

2. _____

3. _____

Do you currently have a birth plan? ○ Yes ○ No

– If yes, please explain:

Are you taking any prenatal or birthing classes? ○ Yes ○ No

– If yes, please explain:

Who is your OB/GYN or midwife? – Will they be present for delivery? ○ Yes ○ No

Who is your birth provider?

Do you intend to have a doula or birth coach present? ○ Yes ○ No

– If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? ○ Yes ○ No

– If not, what concerns do you have?

Your Post Birth Plan

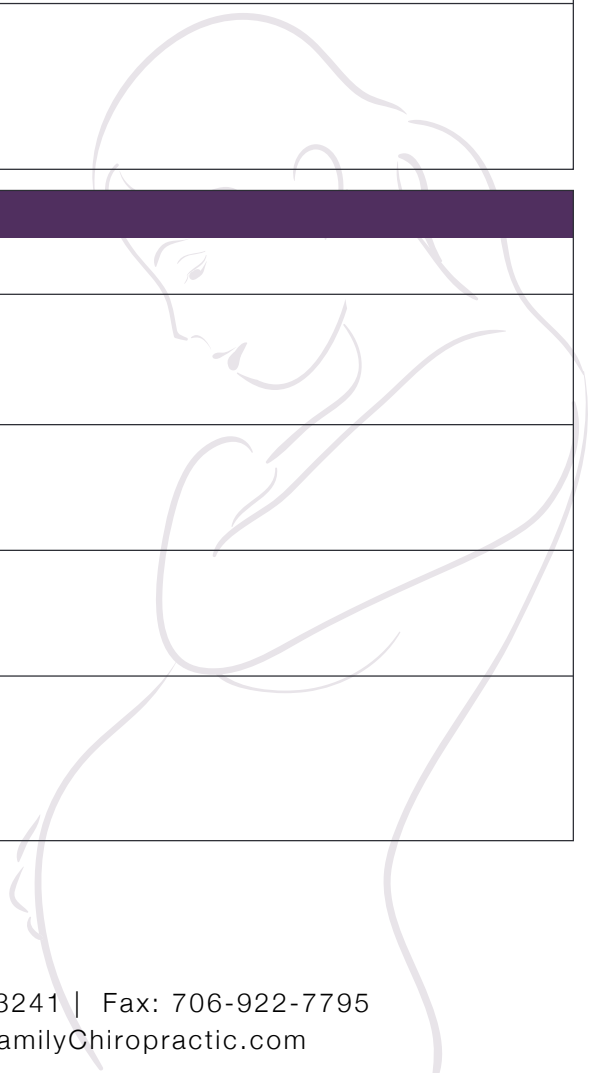
Do you plan on breastfeeding your child? ○ Yes ○ No

What do you intend to do for vaccines?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

What would you like to gain from chiropractic care during your pregnancy?

Are there any burning questions you want to be sure to ask today?



Flack Family Chiropractic

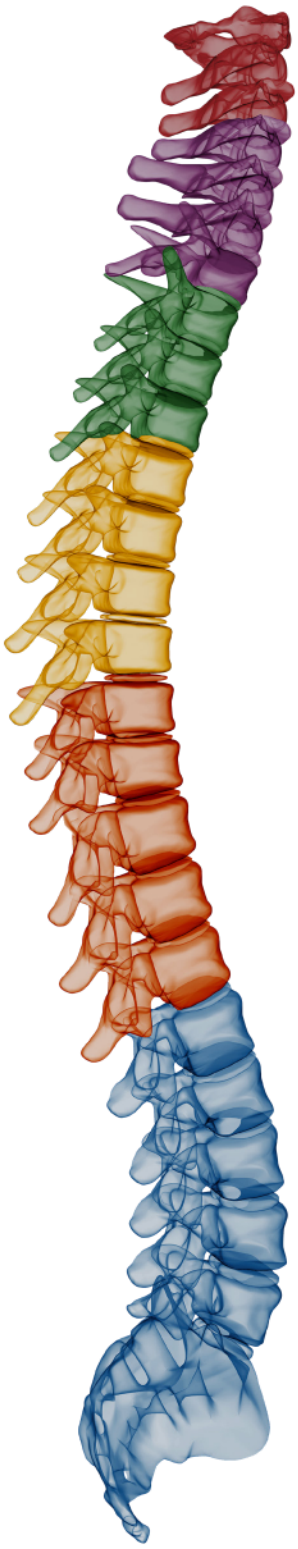
4246 Washington Road Suite 6, Evans, GA | 706-305-3241 | Fax: 706-922-7795

FlackFamilyChiropractic@gmail.com | www.FlackFamilyChiropractic.com

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	
		☐	☐	Ear & Sinus Infections	
		☐	☐	Allergies & Congestion	
		☐	☐	Immune Deficiency	
		☐	☐	Headaches & Migraines	
		☐	☐	Vertigo & Dizziness	
		☐	☐	Sore Throat & Strep	
		☐	☐	Swollen Tonsils & Adenoids	
		☐	☐	Vision & Hearing Issues	
		☐	☐	Low Energy & Fatigue	
		☐	☐	Difficulty Sleeping	
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	
		☐	☐	Epilepsy & Seizures	
		☐	☐	Sensory & Spectrum	
		☐	☐	ADD / ADHD	
		☐	☐	Focus & Memory Issues	
		☐	☐	Anxiety & Stress	
		☐	☐	Balance & Coordination	
		☐	☐	Speech Issues	
		☐	☐	TMJ / Jaw Pain	
		☐	☐	Stiff Neck & Shoulders	
		☐	☐	Depression	
		☐	☐	High Blood Pressure	
		☐	☐	Poor Metabolism & Weight Control	
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	
		☐	☐	Chronic Colds & Cough	
		☐	☐	Asthma	
		☐	☐	Bronchitis & Pneumonia	
		☐	☐	Functional Heart Conditions	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	
		☐	☐	Jaundice	
		☐	☐	Fever	
		☐	☐	Indigestion & Heartburn	
		☐	☐	Stomach Pains & Ulcers	
		☐	☐	Blood Sugar Problems	
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	
		☐	☐	Hyperactivity	
		☐	☐	Chronic Fatigue	
		☐	☐	Chronic Stress	
		☐	☐	Allergies & Eczema	
		☐	☐	Skin Conditions / Rash	
		☐	☐	Kidney Problems	
		☐	☐	Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	
		☐	☐	Chrohn's, Colitis & IBS	
		☐	☐	Diarrhea	
		☐	☐	Bed-wetting	
		☐	☐	Bladder & Urination Issues	
		☐	☐	Cramps & Menstrual Issues	
		☐	☐	Cysts & Endometriosis	
		☐	☐	Infertility	
		☐	☐	Impotency	
		☐	☐	Hemorrhoids	
		☐	☐	Sciatica & Radiating Pain	
		☐	☐	Lumbopelvic / SI Joint Pain	
		☐	☐	Hamstring Tightness	
		☐	☐	Disc Degeneration	
		☐	☐	Leg Weakness & Cramps	
		☐	☐	Poor Circulation & Cold Feet	
		☐	☐	Knee, Ankle & Foot Pain	
		☐	☐	Weak Ankles & Arches	
		☐	☐	Lower Back Pain	
		☐	☐	Gluten & Casein Intolerance	

Patient Name: _____ Date: _____

Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name: | Parent/Guardian Name(s):

Street Address: | City, State, Postal Code:

Cell Phone: | Other Phone: | Child's Sex:

Email: | Child's SSN: | Birthdate: | Age:

How did you hear about us? | Height: | Weight:

Who is your primary care physician?

Is your child receiving care from any other health professionals? ○ Yes ○ No
– If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs or other that your child is taking:

Current Health Conditions

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? | How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Has your child ever received care for this condition? ○ Yes ○ No
– If yes, please explain:

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better? | What makes the problem worse?

Health Goals for Your Child

What are your top three health goals for your child?

1. _____
2. _____
3. _____

What would you like to gain?

○ Resolve existing condition
○ Overall wellness
○ Both

Has your child ever visited a chiropractor? ○ Yes ○ No – If yes, what is their name:

– What is their specialty: ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ Subluxation-based ○ Other:

Pregnancy & Fertility History

Please tell us about your pregnancy:

Any fertility issues? ○ Yes ○ No If yes, please explain: _____

Did mother smoke? ○ Yes ○ No If yes, how often? _____

Did mother drink? ○ Yes ○ No If yes, how often? _____

Did mother exercise? ○ Yes ○ No If yes, please explain: _____

Was mother ill? ○ Yes ○ No If yes, please explain: _____

Any ultrasounds? ○ Yes ○ No If yes, please explain: _____

Please explain any noticable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

Labor & Delivery History

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section – At how many weeks was your child born?

Where was your child born? – Who delivered your baby?

Please indicate any applicable interventions or complications:
◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

Child's birth weight: Child's birth height: APGAR score at birth: APGAR score after 5 min.:

Growth & Development History

Is/was your child breastfed? ◯ Yes ◯ No – If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No – If yes, at what age? – If yes, what type?

Did/does your child suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
– If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
– If yes, please explain:

At what age did the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____
Teethe:_____ Sit alone:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid foods:_____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history (including the year):

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime (including the year):

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
– If yes, please list any vaccine reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
– If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No – If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No – If yes, please explain:

How many hours per day does your child typically spend watching TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

Acknowledgement & Consent

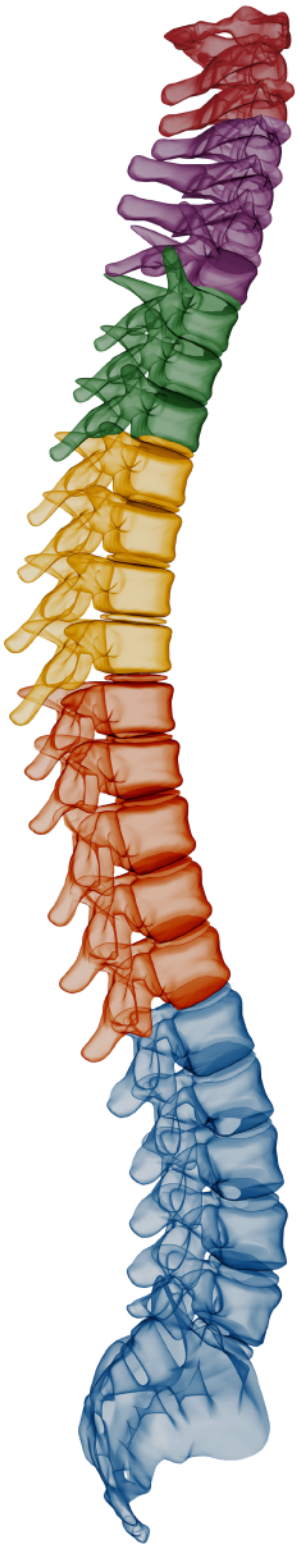
Parent/Guardian Signature: _____ Date: _____

Flack Family Chiropractic
4246 Washington Road Suite 6, Evans, GA | 706-305-3241 | Fax: 706-922-7795
FlackFamilyChiropractic@gmail.com | www.FlackFamilyChiropractic.com

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	
		☐	☐	Ear & Sinus Infections	
		☐	☐	Allergies & Congestion	
		☐	☐	Immune Deficiency	
		☐	☐	Headaches & Migraines	
		☐	☐	Vertigo & Dizziness	
		☐	☐	Sore Throat & Strep	
		☐	☐	Swollen Tonsils & Adenoids	
		☐	☐	Vision & Hearing Issues	
		☐	☐	Low Energy & Fatigue	
		☐	☐	Difficulty Sleeping	
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	
		☐	☐	Epilepsy & Seizures	
		☐	☐	Sensory & Spectrum	
		☐	☐	ADD / ADHD	
		☐	☐	Focus & Memory Issues	
		☐	☐	Anxiety & Stress	
		☐	☐	Balance & Coordination	
		☐	☐	Speech Issues	
		☐	☐	TMJ / Jaw Pain	
		☐	☐	Stiff Neck & Shoulders	
		☐	☐	Depression	
		☐	☐	High Blood Pressure	
		☐	☐	Poor Metabolism & Weight Control	
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	
		☐	☐	Chronic Colds & Cough	
		☐	☐	Asthma	
		☐	☐	Bronchitis & Pneumonia	
		☐	☐	Functional Heart Conditions	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	
		☐	☐	Jaundice	
		☐	☐	Fever	
		☐	☐	Indigestion & Heartburn	
		☐	☐	Stomach Pains & Ulcers	
		☐	☐	Blood Sugar Problems	
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	
		☐	☐	Hyperactivity	
		☐	☐	Chronic Fatigue	
		☐	☐	Chronic Stress	
		☐	☐	Allergies & Eczema	
		☐	☐	Skin Conditions / Rash	
		☐	☐	Kidney Problems	
		☐	☐	Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	
		☐	☐	Chrohn's, Colitis & IBS	
		☐	☐	Diarrhea	
		☐	☐	Bed-wetting	
		☐	☐	Bladder & Urination Issues	
		☐	☐	Cramps & Menstrual Issues	
		☐	☐	Cysts & Endometriosis	
		☐	☐	Infertility	
		☐	☐	Impotency	
		☐	☐	Hemorrhoids	
		☐	☐	Sciatica & Radiating Pain	
		☐	☐	Lumbopelvic / SI Joint Pain	
		☐	☐	Hamstring Tightness	
		☐	☐	Disc Degeneration	
		☐	☐	Leg Weakness & Cramps	
		☐	☐	Poor Circulation & Cold Feet	
		☐	☐	Knee, Ankle & Foot Pain	
		☐	☐	Weak Ankles & Arches	
		☐	☐	Lower Back Pain	
		☐	☐	Gluten & Casein Intolerance	

Patient Name: _____ Date: _____