

# Bearor Family Chiropractic

885 Woodstock Road, Suite 705, Roswell, GA 30075 ♦ 678.585.9956 ♦ 678.585.9957 Fax [www.bfc4health.com](http://www.bfc4health.com)

## Personal Health History

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last Middle Initial First

Address: \_\_\_\_\_

Phone #'s: home \_\_\_\_\_ cell \_\_\_\_\_ work \_\_\_\_\_

Marital Status: † Single † Married Spouse Name: \_\_\_\_\_

# of Children: \_\_\_\_\_ Name(s)/Age(s): \_\_\_\_\_

Email address: \_\_\_\_\_ Would you like to receive our monthly email newsletter? † Yes † No

Reason for coming in: \_\_\_\_\_ Referred by: \_\_\_\_\_

Is condition: † Job Related † Auto Accident † Fall † Home Injury † Other: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Is it reoccurring? † Yes † No Pains are: † Sharp † Dull † Constant † Intermittent

Rate your level of pain on a scale from 1 (minimal pain) to 10 (extreme pain) \_\_\_\_\_

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? † Yes † No Which times? \_\_\_\_\_

Is this condition interfering with: Work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other: \_\_\_\_\_

Is this condition getting progressively worse? † Yes † No

Have you been seen for this problem? † Yes, by: † Physician † Chiropractor † Physical Therapist  
† No † Other: \_\_\_\_\_

What did they do/recommend? \_\_\_\_\_

Have you had previous chiropractic care? † Yes † No When was last visit? \_\_\_\_\_ How often did you go? \_\_\_\_\_

What was the reason for your initial visit there? \_\_\_\_\_

How long were you receiving chiropractic adjustments? \_\_\_\_\_ Why did you discontinue care? \_\_\_\_\_

Are you pregnant? † No † Yes, due date: \_\_\_\_\_ Date of last menstrual cycle: \_\_\_\_\_

## Medications

Are you taking any medications? † Yes † No If yes, list and describe (how long, over the counter, prescription, etc.): \_\_\_\_\_

What side effects (if any) have you experienced from these drugs? \_\_\_\_\_

Have you had surgery? † No † Yes For what? \_\_\_\_\_ When? \_\_\_\_\_

## Accident History (such as auto/work/sport-related/falls/trauma/etc.) **Important Information...**

*All events which could have any impact upon the spine are of high significance to determine spinal history. Please fill out completely.*

Within the past year – when: \_\_\_\_\_ Describe: \_\_\_\_\_

Over a year ago – when: \_\_\_\_\_ Describe: \_\_\_\_\_

Childhood – when: \_\_\_\_\_ Describe: \_\_\_\_\_

Hospitalizations (other than above): \_\_\_\_\_

Birth Trauma? † Yes † No Explain (i.e. forceps, long labor/delivery, C-section, vacuum extraction, etc.) \_\_\_\_\_

Who is responsible your bill? † Self † Spouse † Medicare † Health Insurance † Auto Insurance † Other

If insurance, please present insurance card(s) and photo ID at Front Desk for copying.

Today's Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Last Middle Initial First

**Please check what applies to you...**

Do you purchase: ↑ health food products (organic products, etc.) ↑ Vitamins ↑ Probiotics  
Are you a member of a health club? ↑ Yes ↑ No Exercise: ↑ None ↑ Moderate ↑ Daily ↑ Heavy  
Do you: ↑ Smoke ↑ Drink alcohol – Drinks/week: \_\_\_\_\_ ↑ Drink caffeine/coffee – Cups/day: \_\_\_\_\_  
↑ Consume artificial sweeteners Type: \_\_\_\_\_ ↑ Consume dairy products  
High stress level? ↑ Yes ↑ No If yes, reason: \_\_\_\_\_  
Hobbies: \_\_\_\_\_

**Please check any of the following that have given you difficulty in the last year:**

**General**

- ↑ Headaches
- ↑ Shooting head pain
- ↑ Loss of memory
- ↑ Fatigue
- ↑ Depression
- ↑ Dizziness
- ↑ Thyroid trouble
- ↑ Chills
- ↑ Sweats
- ↑ Sleeping problems
- ↑ Seizures
- ↑ Fainting
- ↑ Irritability
- ↑ Nerves/nervousness
- ↑ Inner tension
- ↑ Weight gain
- ↑ Weight loss
- ↑ Twitching of face
- ↑ Facial pain
- ↑ Jaw pain (TMJ)
- ↑ Menstrual cramps/pain
- ↑ Menstrual irregularity
- ↑ Loss of balance
- ↑ Prostate trouble
- ↑ Cancer
- ↑ Shortness of breath
- ↑ Hernia
- ↑ Arthritis
- ↑ Diabetes
- ↑ Painful joints
- ↑ Swollen joints
- ↑ Ulcers

**Urinary**

- ↑ Bed wetting
- ↑ Blood in urine
- ↑ Frequent urination
- ↑ Lack of bladder control
- ↑ Painful urination
- ↑ Kidney trouble

**Skin**

- ↑ Bruise easily
- ↑ Hives
- ↑ Itching
- ↑ Change in moles
- ↑ Rash
- ↑ Sores that won't heal

**Gastrointestinal**

- ↑ Bowel changes
- ↑ Intestinal gas
- ↑ Constipation
- ↑ Diarrhea
- ↑ Indigestion
- ↑ Nausea
- ↑ Stomach pain
- ↑ Stomach trouble
- ↑ Vomiting blood
- ↑ Gall bladder trouble

**Cardiovascular**

- ↑ Anemia
- ↑ Chest pain
- ↑ Heart attacks
- ↑ Stroke
- ↑ Low blood pressure
- ↑ High blood pressure
- ↑ Poor circulation
- ↑ Irregular heart beat
- ↑ Rapid heart beat
- ↑ Swollen ankles

**Eye/Ear/Nose & Throat**

- ↑ Loss of hearing
- ↑ Earache
- ↑ Sinus trouble
- ↑ Loss of smell
- ↑ Allergies
- ↑ Hay fever
- ↑ Asthma
- ↑ Loss of taste
- ↑ Inflammation of throat
- ↑ Persistent cough
- ↑ Ringing in ears

**Eye/Ear/Nose & Throat continued...**

- ↑ Tonsillitis
- ↑ Blurred vision
- ↑ Sensitivity to light

**Neck**

- ↑ Neck pain
- ↑ Grinding/popping in neck
- ↑ Neck stiffness
- ↑ Pinched nerve in neck
- ↑ Neck feels out of place
- ↑ Muscle spasms in neck

**Shoulders**

- ↑ Shoulder/arm tightness
- ↑ Shoulder/arm pain
- ↑ Pain in shoulder joint
- ↑ Pain across shoulders
- ↑ Can't raise arms
- ↑ Tension in shoulders
- ↑ Pinched nerve in shoulders

**Mid Back**

- ↑ Mid-back pain
- ↑ Spinal curvature
- ↑ Mid-back stiffness
- ↑ Pain between shoulder blades
- ↑ Pain from front to back
- ↑ Muscle spasms in mid-back

**Low Back**

- ↑ Low-back pain
- ↑ Low-back stiffness
- ↑ Low-back weakness
- ↑ Low-back feels out of place
- ↑ Muscle spasms in low-back

**Arms & Hands**

- ↑ Pins & needles in arms
- ↑ Pins & needles in hands
- ↑ Numbness in arms/hands
- ↑ Pain in upper arm
- ↑ Pain in elbow
- ↑ Pain in forearm
- ↑ Pain in hand
- ↑ Pain in fingers
- ↑ Weakness of hand
- ↑ Cold hands

**Hips/Legs & Feet**

- ↑ Cold feet
- ↑ Pain in buttocks
- ↑ Pain in hip joint
- ↑ Pain down leg
- ↑ Pain in knee
- ↑ Pain in ankle
- ↑ Pain in foot
- ↑ Weakness of leg
- ↑ Weakness of knee
- ↑ Leg cramps
- ↑ Pins & needles in legs
- ↑ Numbness in legs/feet

**BEAROR FAMILY CHIROPRACTIC**  
**INFORMED CONSENT FOR**  
**CHIROPRACTIC CARE**

---

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Bearor Family Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

---

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

---

Patient Name (printed)

---

Relationship to Patient

# BEAROR FAMILY CHIROPRACTIC

## 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 or correction is by specific adjustment 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 vertebrae 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 diseases 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 another health care provider.

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.

### Pregnancy Release

This is to certify that to the best of my knowledge I am **not** pregnant and the above doctor and his associates have 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 to Care

I do hereby authorize Dr. Nathan Bearor to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure which is advisable, and necessary for my health care.

I, \_\_\_\_\_, have read, understand, and hereby request chiropractic care based on the terms of acceptance and the consent to care.

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

(signature of parent or guardian if minor)

# HIPPA HAPPENINGS

## BEAROR FAMILY CHIROPRACTIC

### Patient Authorization regarding chiropractic care being provided in an “open adjusting” environment

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patients histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. It is also the practice of this office to display, on a bulletin board, patients celebrating a birthday each month, as well as displaying each new patient and the person who referred them to our office.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosure” of health information. It is our view that the kinds of matters related in an “open adjusting” environment are incidental matters; in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an “open adjusting” environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Nate or on your relationship with our staff.

Your signature indicates your authorization of this activity.

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.