Falite Family Chiropractic

Drs. Dawn & Michael Falite
770-667-2232
2910 Vaughan Dr, Cumming, GA 30041
www.FaliteChiropractic.com

Name:_____ Date:_____

Parent Name (if minor):_____

Address:_____ City:_____ Zip:_____

Date of Birth:_____ Age:_____ Marital Status: M S D W

Occupation:_____ Employer:_____

Phone (home):_____ (cell):_____

(work):_____ email:_____

Spouse's Name & DOB:_____ Spouse's Employer:_____

Names & Ages of Children/siblings:_____

Hobbies:_____

Who referred you to our office:_____ Relationship:_____

Primary reason for consulting our office:_____

_____

Past Trauma/Surgeries/Illnesses:
What accidents/surgeries/major illnesses have you had? (i.e. car, bicycle, sports, slips/falls, spinal surgery, cancer, stroke, etc.) Please include approximate dates:_____

_____

Medication:
Have you received a Covid shot? Yes / No If Yes, when:_____
Please refrain from coming to the office within 2 weeks of receiving ANY vaccine due to shedding
Past/Present prescription or over-the-counter drugs:_____

_____

Current Health:
How would you describe your current health?_____
Level of stress: mild / moderate / severe
Do you use any of the following? tobacco / alcohol / coffee / cola / milk / artificial sweeteners
Do you use any of the following? purified water / vitamins / health foods / organic foods

OVER

Please circle any of the following symptoms you have had or are having now. Number the top three complaints that you hope to improve (#1, #2, #3).

Immune System
Allergies
Asthma
Frequent colds/infections
Yeast infections
Fatigue

Sleep
Difficulty falling asleep
Wakeful/restless
Difficulty waking up
Nightmares
Snoring
Sleepwalking

Eyes
Double/blurred vision
Blind spots

Ear/Nose/Throat
Hearing loss
Ringing in ears
Earaches
Sense of smell changed
Sinus problems
Grinding teeth
Sense of taste changed
Hoarseness or sore throat

Heart/Lungs
Problems breathing
Heart problems
Hypertension
Palpitation
Dizziness

Hormonal/Blood
Appetite increase/decrease
Diabetes
Crave sweets/carbs
Sensitive to heat/cold
Thyroid problems
PMS symptoms
Menopause symptoms
Low/high libido

Bones/Joints/Muscles
Pain/stiffness in joints/muscles
Sore points in muscles
Fibromyalgia
Bodily fatigue

Nervous System
Headaches/migraines
Fainting
Seizures
Memory loss
Blocking on words
Reading problems
Difficulty speaking
Tremor/shaking
Weakness
Hyperactivity
Balance issues
Motor/vocal tics

Attention/Organization
Difficulty focusing
Easily distracted
Make mistakes
Difficulty organizing activities
Not completing tasks
Lose train of thought

School/Learning
Difficulty completing work
Poor reading comprehension
Inverting letters/numbers
Spatial problems
Difficulty w/particular class

Bowel/Bladder
Difficulty urinating
Difficulty holding urine
Difficulty controlling bowels
Frequent bladder infections

Habits
Sometimes drink too much
Smoke cigarettes
Concerns about your diet
Desire caffeine
Use marijuana
Other addictions

Behavior/Emotions
Mood swings
Feeling down/depressed
Feel sad
Feeling anxious
Panic attacks
Worry
Thoughts that won't stop
Need to repeat actions
Bingeing
Restricting your food intake
Making yourself vomit
Phobias/avoiding things
Feeling paranoid
Unhealthy behaviors
Feeling angry often
Impulsive
Feeling overwhelmed
Discipline issues

Other:_____

We look forward to helping you!!!

HEALTH CARE AUTHORIZATION FORM

You are being provided with a copy of this Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of your Protected Health Information (PHI) that will occur during your treatment, payment of your bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes your rights and the duties of the Chiropractor with respect to your protected health information. By signing below, you are giving permission to Falite Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to FFC to use my address, phone number, email and clinical records to contact me with texts, appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives and/or other health related information.
- If FFC contacts me by phone or text, I give them permission to leave a voicemail or text message.
- I give permission to FFC to have my name on a sign-in sheet.
- I give permission to FFC to use my photograph on their marketing materials such as their brochures, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, Google reviews, sharing with other patients or potential patients, in their brochures, on their website, or in ads in print media.
- I give FFC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above. 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. This authorization will remain in effect for the duration of your care at Falite Family Chiropractic, plus 7 years or until revoked by yourself.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of FFC. The written notice must contain the following information: your name, Social Security number and date of birth; a clear statement of your intent to revoke this AUTHORIZAITON; the date of your request; and your signature. The revocation is not effective until it is received by the Privacy Official. This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. *(Minimum necessary standards apply)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment, however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.* I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Today's Date:_____

Patient's name (please print):_____ DOB:_____

Signature:_____ Relationship to Patient:_____