DR. ERIN M. FARAHANI
Doctor of Chiropractic

109 S. Ohio Street
Celina, TX. 75009

Tell#: (972) 382-4849
Fax#: (972) 382-4809

Patient Confidential Personal Data

PLEASE PRINT CLEARLY

Full Name: _____ DOB: _____ Age: _____ Gender: ☐M ☐F

Address: _____City: _____State: _____Zip: _____

Social Security#: _____ - _____ -_____ Drivers License#/State: _____ /_____Marital Status: ☐S ☐M ☐D ☐W# of Children ___

Home PH#: _____ Cell PH#:_____Fax PH#: _____
E-mail Address: _____

Employer Name: _____ Occupation: _____ Work#: _____

Employer Address: _____City: _____State: ____Zip: _____

Name of Spouse/ Guardian: _____ DOB: _____Age: _____ Social Security#: _____ - _____ -_____

Spouse/ Guardian Employer: _____ Spouse's Occupation: _____ Work#: _____

In case of Emergency Contact: _____ Relationship: _____

Home PH#:_____Cell PH#: _____Work PH#:_____

How did you hear about our clinic? Whom may we thank for referring you? _____

Reason for this appointment today? _____

Date Problem Started: _____ How Did Problem Start? _____

Date of Last Injury/Accident:_____ How Did it Happen? _____

Name of Primary Physician _____Phone#: _____

INSURANCE ASSIGNMENT OF BENEFITS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. **I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.** I hereby direct the reimbursement and irrevocably assign to benefits of my insurance policies for all services provided by Dr. Erin M. Farahani, D.C. be paid directly to Dr. Erin M. Farahani, D.C., 109 S. Ohio St, Celina, TX, 75009, the provider of services, under terms of my contract with the insurance company. I further grant to Dr. Erin M. Farahani, D.C. the power to endorse my name upon any checks or drafts representing payment for services provided.

RECORDS RELEASE AUTHORIZATION

I hereby authorize you to release to Dr. Erin M. Farahani, D.C. all records and information including but not limited to the examination, diagnosis, records of treatment, radiographs, and reports.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby authorize Dr. Erin M. Farahani, D.C. to treat my condition, as she deems appropriate through use of chiropractic manipulation throughout my spine and the joins of my skeleton. Dr. Erin M. Farahani, D.C. will not be responsible for any pre-existing medical conditions, nor for any medical diagnosis.

SIGNATURE: _____ Date: _____

INFORMED CONSENT FOR NON-COVERED SERVICES BY MEDICARE, MEDICAID, AMERIGROUP, AND OTHER MEDICAID SUBMANAGED HEALTHPLAN. I understand and agree that my insurance will only cover spinal manipulation performed by Dr. Erin M. Farahani. Therefore, x-rays and other therapies that are performed by her will be out of pocket expenses and I will be responsible to pay at the time of service.

SIGNATURE: _____ Date: _____

Please indicate for each question below your experience by using a check mark. (P=Past/ C=Current)

P/C	P/C	P/C	P/C
□ □ Headaches	□ □ Black stool	□ □ Constipation	□ □ Chest pain
□ □ Neck problems	□ □ Bloody stool	□ □ Convulsions/Seizures	□ □ Hoarseness
□ □ Tingling in hands	□ □ Excessive urination	□ □ Eye strain	□ □ Eye inflammation
□ □ Pain between shoulders	□ □ Decreased urination	□ □ Blurred vision	□ □ Sore mouth
□ □ Arm problems	□ □ Discolored urine	□ □ Vision problems	□ □ Sinus Problems
□ □ Elbow/Hand problems	□ □ Painful urination	□ □ Ear pain	□ □ Difficulty speech
□ □ Facial Pain	□ □ Hemorrhoid	□ □ Hearing loss	□ □ Fatigue
□ □ Carpel Tunnel pain	□ □ Leg problems	□ □ Ear noises	□ □ Sweating
□ □ Knee pain	□ □ Heartburn	□ □ Nose bleeding	□ □ Impatience
□ □ Painful joints	□ □ Weight trouble	□ □ Sore gums	□ □ Fainting
□ □ Stiff joints	□ □ Poor appetite	□ □ Sore throat	□ □ Lump in throat
□ □ Swollen joints	□ □ Excessive hunger	□ □ Loss of control	□ □ Irritability
□ □ Sore muscles	□ □ Insomnia	□ □ Gallbladder problems	□ □ Dizziness
□ □ Weak muscles	□ □ Difficulty chewing	□ □ Liver trouble	□ □ Shakiness
□ □ Low back problems	□ □ Difficulty swallowing	□ □ Bladder trouble	□ □ Lung problems
□ □ Walking problem	□ □ Teeth Grinding	□ □ Nausea	□ □ Poor Circulation
□ □ Restless legs	□ □ Difficulty breathing	□ □ Abdominal pain	□ □ Blood pressure problems
□ □ Numbness in legs	□ □ Persistent coughing	□ □ Diarrhea	□ □ Heart problems
□ □ Loss of feeling	□ □ Excessive thirst	□ □ Varicose veins	□ □ Rapid heartbeat
□ □ Paralysis	□ □ Coughing blood	□ □ Edema	For FEMALE Only
□ □ Tingling in feet	□ □ Vomiting food	□ □ Depression	□ □ Menstrual Irregularities

COMPLAINT/PROBLEM: *In relation to your primary complaint:*

What is your current health problem or complaint?

_____

When did you first seek treatment for this problem? __/__/___. Have you seen other doctors for this conditions? Y □ N □ if so, which doctor?

_____

How many days within the past year have you suffered with this condition? _____ . How long has this episode lasted?

_____

Is your condition accident related? □ Yes □ No if so, was the accident related to: Work □ Auto □ Other □

_____

Date of accident: __/__/____ Time of accident: ___:____ am/ pm location:

_____

Do you have an attorney advising you? □ Yes □ No if so, which attorney/firm:

_____

Are you pregnant? □ Yes □ No if not, date of LMP_____

Circle the activities affected by this problem. Difficulty with: sleeping, getting up out of bed/ chair, getting dressed, brushing teeth, fixing hair, sitting down, driving, bending, lifting objects off floor, standing, dancing, lying down, pushing/ pulling, etc. explain below:

_____

When was your last accident? (Auto, slip & falling, lifting, etc…)

_____

What have you previously tried to help today's problem?

_____

When the problem is at its worst, does it make you feel older than you are? Yes No How old?

_____

What activities does this problem prevent you from doing that you would like to be able to do again?

_____

Is there anything preventing you from getting this problem taken care of?

_____

What do you think is causing your problem?

_____

Have you ever been treated by a chiropractor before? Y □ N □ Age when you first experienced spinal problems: _____years

Have you had x-rays taken of the following: Back □ Neck □ Chest □ other □ Last X-Ray Date: ___/___/____

Have you been treated for any other health conditions in the past year? Y □ N □

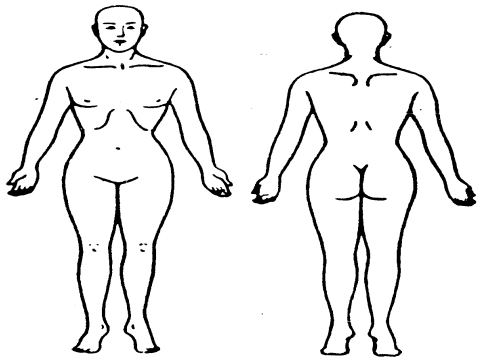
If so, please identify:

_____

**** Please use the legend symbols below to accurately mark the areas in which you feel these sensations.***

SORENESS (S) STABBING/SHARP (X) BURNING (B) NUMB (N) TINGLING (T) CRAMPING/STIFF (C) DULL (D)

Please indicate the severity of your pain:



TREATMENT: *What type of treatment are you looking for?*

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.

☐ I am looking to resolve my symptoms and then go to "fix the cause" of my problem.

☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

HEALTH CONCERNS: *Please list your health concerns in order of priority:*

_____

_____

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Soda/Diet Soda	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type
Exercise	☐	☐	☐	☐	
	8+hr	7-8hr	6-7hr	<5hr	
Sleep	☐	☐	☐	☐	
	5+	4	3	2	
Meals/day	☐	☐	☐	☐	
	64+oz	32-64oz	16-32oz	<8oz	
Water/day	☐	☐	☐	☐	

WORK ACTIVITY:

☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Computer Work ☐ Walking/Moving ☐ Driving

ALLERGIES: *Please check and list all allergies.*

☐Food:_____

☐Medications:_____

☐Seasonal/Other:_____

SUPPLEMENTS: *Do you take Vitamins/Supplements or Herbs?* ☐ Yes ☐ No *if yes, who recommended them?*

_____

MEDICATIONS: *Please check and list all medications that you are currently taking with the date you began taking them.*

Type	Medication Name	Date Started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacement(HRT)		
☐ Oral Contraceptives		
☐ Other		

SCARS/SURGICAL PROCEDURES: *List all scars and surgical procedures you have had.*

_____

_____

FAMILY HISTORY: *Identify any conditions that you, or any of your family members have now or have had in the past: (**G** = Grandparents, **M** = Mother, **F** = Father, **S** = Siblings, **X** = Self)*

____ Alcoholism	____ Eczema	____ Miscarriage(s)	____ Tumor(s)
____ Anemia	____ Emphysema	____ Mumps	____ Ulcers
____ Cancer	____ Epilepsy	____ Pleurisy	____Other:_____
____ Cold sores	____ Goiter	____ Pneumonia	_____
____ Deep vein thrombosis	____ Gout	____ Polio	_____
____ Detached retina	____ Heart disease	____ Rheumatic fever	
____ Diabetes	____ HIV/ AIDS	____ Stroke	

_____

Patient's Printed Name

Patient's Signature Date

DOCTOR ONLY **DATE**

Chief Complaint: (family and past medical history)

Present Illness: _____

Onset: ❑ Sudden ❑ Gradual ❑ Traumatic
Provocative and Palliative: Activities Positions Movement_____
Quality of Symptom: Dull ❑ Ache ❑ Throbbing ❑ Stabbing ❑ Burning ❑ Sharp
Radiating: Which side Extent Location_____
Site Specific: Intensity of Pain (1-10)_____
Frequency of Pain: ❑ Occasional (0-25%) ❑ Intermittent (25-50%) ❑ Frequent (50-75%) ❑ Constant (75-100%)
Time Specific: ❑ Worse in Morning ❑ Worse in Evening Time Specific Pain_____

Examination: BP: _____ & PR _____ TEMP: _____ WT: _____ HT: _____

Appearance: _____

Pain & Tenderness:

_____
Palpation/Pain Scale

Asymmetry/Misalignment:

_____
Posture/Gait/Palpation/Diagnostic Imaging

Range of Motion Abnormality:

_____
Motion Palpation/Observation

Tissue, Tone Changes:

_____
Observation/Palpation

Neuro/Ortho Test:

_____

Diagnose:
❑ **M9900** ❑ **M9901** ❑ **M9902** ❑ **M9903** ❑ **M9904** ❑ **M9905**

_____

Procedures:

_____

X-Rays:

_____

Treatment Plan:

_____
(Duration & Frequency of visits)

Specific Treatment Goal:

_____

Evaluation of Treatment Effectiveness:

_____

Celina Family Chiropractic Clinic

109 S. Ohio Street, Celina, TX 75009
Tel: 972-382-4849, Fax: 972-382-4809

CONSENT TO X-RAY

I hereby authorize Celina Family Chiropractic Clinic and whomever the clinic and may designate as their assistant(s) to take x-rays.

Date this _____ day of _____ , 20 _____

Signed: _____

FEMALE ONLY

VERIFICATION OF NON-PREGNANCY

Date of the last menstrual period (LMP): _____

By my signature on this form, I _____ do hereby state that, to the best of my knowledge, I am not pregnant, or if pregnancy suspected or confirmed at this particular time, I hereby released Celina Family Chiropractic Clinic from any and all liability.

Date this _____ day of _____ , 20 _____

Signed: _____

Witness _____

**Must be complete for all females of childbearing age and signed in the patient's own handwriting.

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Erin M. Farahani, DC and whomever she designates as her assistants to administer chiropractic care that she deems necessary to my _____ (Relation to Child).

Name of Child: _____ Age: _____

Date this _____ day of _____ , 20 _____

Signed: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

OF ***Celina Family Chiropractic Clinic***
109 S. Ohio Street
Celina, Texas 75009
972-382-4849

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Celina Family Chiropractic Clinic's "Notice of Privacy Practices" has been provided to me. I understand that I have a right to review Celina Family Chiropractic Clinic's Notice of Privacy Practices prior to signing this document. Celina Family Chiropractic Clinic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Celina Family Chiropractic. The Notice of Privacy practices for Celina Family Chiropractic is also provided on request at the front desk of this practice. This Notice of Privacy Practices also describes my rights and Celina Family Chiropractic Clinic's duties with respect to my protected health information.

Celina Family Chiropractic Clinic's reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Assignment of Benefits and Authorization for Release of Medical Records

I, the undersigned, assign directly to **Dr. Erin Farahani, at Celina Family Chiropractic Clinic** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits to **Dr. Erin Farahani**.

_____ _____
Signature of Insured/Guardian Date

CELINA CHIROPRACTIC CLINIC
Since 1997

Radiology Report

Date:

Patient Name:
DOB:

❑EXTREMITY (IES) _____
❑AP/Lateral Cervical, Thoracic, and Lumbar Spines.

❑There is no evidence of acute fracture, dislocation, and/or osseous destruction or vertebral body compression, and soft tissue calcification or mass lesion in cervical, thoracic, and lumbar spines.

❑There is no evidence of acute fracture, dislocation, and/or osseous destruction, and soft tissue calcification or mass lesion in_____.

Should you have any questions and concerns, please feel free to contact my office.

Sincerely,

Dr. Erin Farahani
Clinic Director

Tel: 972.382.4849 | info@cfcctx.com | 109 S. Ohio Street
Fax: 972.382.4809 | www.cfcctx.com | Celina, TX 75009