

**DR. ERIN M. FARAHANI**  
**Doctor of Chiropractic**

**109 S. Ohio Street**  
**P.O. BOX 822**  
**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 Erin M. Farahani, D.C. be paid directly to 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 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 Erin M. Farahani, D.C. all records and information including but not limited to the examination, diagnosis, records of treatment, radiographs, and reports.

*INFORMED CONSTANT TO CHIROPRACTIC TREATMENT*

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

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

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

What is your current health problem or complaint?

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

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

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

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Date of accident: \_\_\_/\_\_\_/\_\_\_\_ Time of accident: \_\_\_\_:\_\_\_\_ am/ pm location:

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

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Are you pregnant?  Yes  No if not, date of LMP \_\_\_\_\_

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**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:

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

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

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

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

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

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What do you think is causing your problem?

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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:

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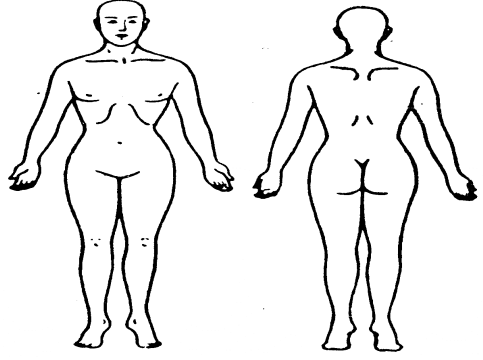
\* Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

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	Exercise	5-7x/wk	3-5x/wk	1-3x/wk	None	Type
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	8+hr	7-8hr	6-7hr	<5hr	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		5+	4	3	2	
Soda/Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meals/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		64+oz	32-64oz	16-32oz	<8oz	
					Water/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-Diabetics		
<input type="checkbox"/> Anti-Inflammatory		
<input type="checkbox"/> Blood Pressure Lowering Meds.		
<input type="checkbox"/> Cholesterol Lowering Meds.		
<input type="checkbox"/> Hormone Replacement(HRT)		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> Other		

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

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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)*

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Miscarriage(s)  | <input type="checkbox"/> Tumor(s)     |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Ulcers       |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Pleurisy        | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cold sores           | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Pneumonia       | _____                                 |
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Gout          | <input type="checkbox"/> Polio           | _____                                 |
| <input type="checkbox"/> Detached retina      | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic fever |                                       |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> HIV/ AIDS     | <input type="checkbox"/> Stroke          |                                       |

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Patient's Printed Name

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Patient's Signature

Date

**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 is 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 designate as her assistants to administer chiropractic cares 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, POB 822  
Celina, Texas 75009-0822  
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. **Farahani, at Celina Family Chiropractic** 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