



**DR. GREG & DR. TAMARA LOGAN**  
 5560 BEE RIDGE ROAD, SUITE D7  
 SARASOTA, FLORIDA 34233  
**941-927-1123 Fax 941-927-1124**  
[www.LoganFamilyChiropractic.com](http://www.LoganFamilyChiropractic.com)

<b>Office Use Only:</b>	<input type="checkbox"/> Ph 1
ROF Date: _____	<input type="checkbox"/> Ph 2
_____	<input type="checkbox"/> Ph 3
<input type="checkbox"/> Other _____	

First \_\_\_\_\_ MI. \_\_\_\_\_ Last \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ E-mail \_\_\_\_\_  
 Social Security # \_\_\_\_\_ **Circle One:** Married / Single / Widowed / Divorced / Separated  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Spouse Name \_\_\_\_\_ # of Children \_\_\_\_\_  
**FEMALES:** Are you pregnant? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, How many weeks? \_\_\_\_\_ Date of last menstrual cycle? \_\_\_\_\_

- **Most patients are referred to our office. What made you decide to visit our office?**  
 Friend/Family \_\_\_\_\_  Telephone Call  Website  Presentation  Other \_\_\_\_\_
- **How many times** have you **visited a chiropractor** in your lifetime? \_\_\_\_\_  Never
- **When was your last spinal examination**, including **x-rays**? \_\_\_\_\_  Never
- **Who is Responsible for Your Bill? You &**  No Insurance  Major Medical  Auto  Medicare  Medicaid
- **Poor posture** leads to poor health and often **indicates a spinal problem**. How would you rate **your posture**?  
**Poor** 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **Excellent**

**MAJOR COMPLAINT** \_\_\_\_\_

- **Date** when symptoms first appeared: \_\_\_\_\_ Have you had this condition before? Y N
- **How long** have you been experiencing your **complaint**?  Days  Weeks  Months  Years
- Is your **condition getting**...  Worse  Same  Better
- What makes it **worse**?  Sitting  Standing  Lying  Walking  Activity  Other \_\_\_\_\_
- What have you **tried** that **did not work**?  Ice/ Heat  Prescrip. Meds.  Over The Counter Meds.  Other \_\_\_\_\_
- **Circle the severity** of your **complaint** (at its worst, **1= mild, 10= severe**):  
 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
- **Circle the percentage of time** you experience your **complaint**:  
 10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

**OTHER COMPLAINT** \_\_\_\_\_

- **Date** when symptoms first appeared: \_\_\_\_\_ Have you had this condition before? Y N
- **How long** have you been experiencing your **complaint**?  Days  Weeks  Months  Years
- Is your **condition getting**...  Worse  Same  Better
- What makes it **worse**?  Sitting  Standing  Lying  Walking  Activity  Other \_\_\_\_\_
- What have you **tried** that **did not work**?  Ice/ Heat  Prescrip. Meds.  Over The Counter Meds.  Other \_\_\_\_\_
- **Circle the severity** of your **complaint** (at its worst, **1= mild, 10= severe**):  
 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
- **Circle the percentage of time** you experience your **complaint**:  
 10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**NP-1**

**OTHER COMPLAINT / NOTES:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST HEALTH HISTORY**

- **Major Surgery / Operations:**  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery  
 Broken Bones  Other \_\_\_\_\_
- **Auto Accidents ,Slips or Falls:** \_\_\_\_\_
- **Hospitalizations** (other than above): \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:**

**MUSCULO-SKELETAL**

- Neck Pain
- Arm Pain
- Pain between Shoulders
- Mid-Back Pain
- Low Back Pain
- General Stiffness
- Joint Pain / Stiffness
- Walking Problems
- Clicking Jaw

**NERVOUS SYSTEM**

- Nervous
- Numbness \_\_\_\_\_
- Paralysis
- Dizziness
- Forgetfulness
- Confusion / Depression
- Fainting
- Cold/ Tingling Extremities
- Convulsion

**GENERAL**

- Headaches
- Allergies
- Loss of Sleep
- Fever
- Fatigue
- Anxiety
- Difficulty Breathing
- Chronic Cough
- Asthma

**EYE / EAR / NOSE / THROAT**

- Vision Problems
- Ringing / Buzzing Ears
- Vertigo (Dizziness)
- Ear Infections
- Hearing Difficulty
- Sinus Problems
- Sore Throat
- Difficulty Swallowing
- Thvroid Problems

**GI ( GASTROINTESTINAL)**

- Upset Stomach
- Loss of Appetite
- Indigestion
- Constipation
- Diarrhea
- Blood in Stool
- Abdominal Pain
- Heartburn
- Gas / Bloatina after meals

**CARDIOVASCULAR ( HEART )**

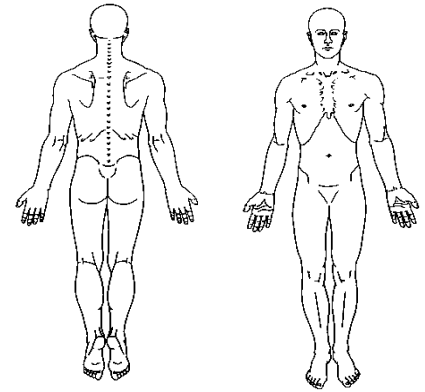
- Chest Pain
- Difficulty Breathing
- Shortness of Breath
- Palpitations
- Night Sweats
- Cold Extremities
- High Blood Pressure
- Low Blood Pressure
- Heart Murmur

**MALE / FEMALE**

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain / Infection
- Breast Pain / Lumps
- Frequent Urination
- Sexual Dysfunction
- Prostate Problems
- Hernias
- Testicular Pain

**PAIN DIAGRAM** →

Place an "X" on the drawing where you experience pain & draw an "↗" where you experience pain radiating / shooting down your arms or legs.



**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Logan Family Chiropractic**

I hereby give my consent for **Logan Family Chiropractic** (hereinafter referred to as the "Practice") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

**Rhae Ann Ongstad**, Office Manager, at the following address:

5560 Bee Ridge Road, Suite D7, Sarasota, FL 34233.

With this consent, the Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to my items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Patient or Legal Guardian**



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**THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE**

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 for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific, scientific adjustment of the spine.

**Health:** A state of optimal, physical, mental, and social well being, not merely the absence of disease, symptoms or infirmity.

**Vertebral Subluxations:** 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 disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

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 to the body's innate wisdom. Our only method is the specific, scientific adjustment of vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

**Release And Assignment:** I authorize release of any information necessary to process my insurance claims, and assign and request payment directly to my physician.

**POLICIES**

1. All first visit charges are payable when services are rendered, since it is impossible to determine what insurance covers without a diagnosis of severity.
2. The fee paid for X-Rays is for the analysis of those X-Rays only. The film itself is the property of this office. Copies can be made at a minimal fee.
3. **Method of payment for today's charges:**  Cash  Check  Visa / MasterCard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Logan Family Chiropractic (LFC) will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to LFC will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

**In case of emergency, notify** \_\_\_\_\_ **(Relationship)** \_\_\_\_\_ **Phone#** \_\_\_\_\_

I, \_\_\_\_\_ **have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on that basis.**

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

