HEALTH RECORD

ABOUT YOU

Name_____

Address_____

City_____ State_____

Zip _____Home phone _____

Birth date _____ Cell Phone_____

Age _____ Gender _____ Number of children _____

Employer_____

Work address _____

Work phone _____

Occupation _____

Marital Status _____

Social Security # _____

E-mail address_____

Payment method ☐ Cash ☐ Check

☐ Credit card ☐ Insurance Support

ABOUT YOUR SPOUSE

Name _____

Employer _____

Work phone _____

Type of work _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall

☐ Home Injury ☐ Chronic Discomfort ☐ Other

Please explain _____

If job related, have you made a report of your accident to your employer?

☐ Yes ☐ No

When did this condition begin? _____

Has this condition:

☐ gotten worse ☐ stayed constant ☐ comes and goes

Does this condition interfere with:

☐ Work ☐ Sleep ☐ Daily routine ☐ Other activities

Please explain _____

Has this condition occurred before? ☐ Yes ☐ No

Please explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name (s) _____

Type of treatment _____

Results _____

EXPERIENCE WITH CHIROPRACTIC

How did you hear about our office?_____

Have you seen or heard about us in/on: ☐ Paper ☐ Sign ☐ Phone Book

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits? _____

Doctor's name:_____

Approximate date of last visit:_____

Has anyone in your family seen a Chiropractor? ☐ Yes ☐ No

HEALTH HABITS

	No	Yes
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you drink coffee, tea or soda?	☐	☐
Do you exercise regularly?	☐	☐

Height _____ Weight _____

AWARENESS OF THE CHIROPRACTIC PRINCIPLES

Were you aware that:

Doctors of Chiropractic work with the nervous system?	☐ Yes	☐ No
The nervous system controls all bodily functions and systems?	☐ Yes	☐ No
Chiropractic is the largest natural healing profession in the world?	☐ Yes	☐ No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ **Relief care** – Symptomatic relief of pain or discomfort
- ☐ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptom
- ☐ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- ☐ **I want the Doctor to select the type of care appropriate for me.**

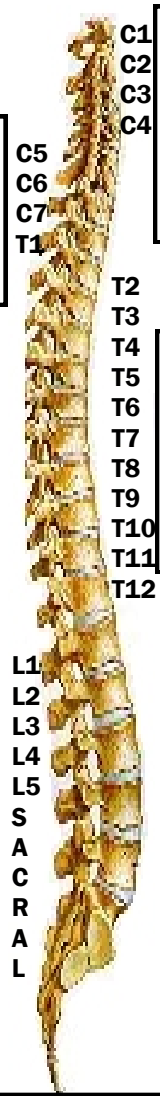
MEDICATIONS I NOW TAKE...

- ☐ Cholesterol medication
- ☐ Blood pressure medicine
- ☐ Stimulants
- ☐ Blood thinners
- ☐ Tranquilizers
- ☐ Pain killers (including aspirin)
- ☐ Muscle relaxers ☐ _____
- ☐ Insulin ☐ _____

Vitamins & Supplements I now take:_____

_____

Please circle the health concern or concerns you may be experiencing now or have experienced in the past. Each area of concern relates to an area of the spine and nerve function.



Headaches
Migraines - Dizziness
Sinus Problems
Allergies - Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Sore Throat - Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma –Allergies
High Blood Pressure
Heart Conditions

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis - Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers - Gastritis
Kidney Problems

Constipation - Colitis
Diarrhea - Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

Other:_____
_____
_____
_____
_____
_____
_____
_____
_____

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall evaluation, care plan and the possibility of being accepted for care.

- ☐ Severe or frequent headaches
- ☐ Kidney Problems
- ☐ Sinus problems
- ☐ Shingles
- ☐ Ulcers / Colitis
- ☐ Asthma
- ☐ Loss of sleep
- ☐ Pain between shoulders
- ☐ High/Low High blood pressure
- ☐ Difficulty breathing
- ☐ Frequent neck pain
- ☐ Numbness
- ☐ Frequent Colds
- ☐ Heart surgery/pacemaker
- ☐ Arthritis
- ☐ Heart attack/stroke
- ☐ Dizziness
- ☐ Tuberculosis
- ☐ Digestive problems
- ☐ Congenital heart defect
- ☐ Chemotherapy
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Surgeries _____
- ☐ Pain in arms/legs/hands
- ☐ Lower back problems

For women:

Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking birth control?	☐ Yes	☐ No
Do you experience painful periods?	☐ Yes	☐ No
Do you have irregular cycles?	☐ Yes	☐ No

Terms Of Acceptance

When a patient seeks chiropractic 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 methods that will be used to attain it. This will prevent confusion, misunderstanding or disappointment.

Subluxations are interferences to the normal flow of mental impulses traveling over the nerve pathways. It is a chiropractor's goal to locate, analyze, and correct those spinal subluxations so that proper nerve function is returned to the body.

The method of correction is by specific adjustments of the spine. These adjustments are intended to reduce subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency. With a proper nerve supply restored through chiropractic adjustments, the body can begin the process of repair, leading to better health. In some patients, this happens quickly; in others, more slowly. In some patients, the repair and maintenance is complete; in others, only partial.

We do not offer to diagnose or treat any disease or condition other than spinal subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease, the chiropractor is not offering to heal, treat, or cure it. Our goal is to allow the body to do the best that it can without nerve interference.

The chiropractic examination and adjustment are not substitute for other types of health care, just as other types of care do not take the place of chiropractic. Being free of subluxation is complimentary to any procedure that is life-enhancing.

I, _____, have read the above, understand it fully and undertake chiropractic care on this basis.

_____

Signature Date

COMPLETE IF PATIENT IS A MINOR CHILD:

_____

Print Child's Name

I, _____, being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____

Signature Date

AUTHORIZATIONS

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt.

_____ _____

Patient's Name (print) Date

_____ _____

Signature Authorizing Care (or Parent/Guardian's Signature) Date

Who should receive bills for payment on your account?

☐ **Patient** ☐ **Spouse** ☐ **Parent** ☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Medicare** ☐ **Health Insurance**

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray originals will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office. Upon my signature, x-rays may be released to another provider for a loan period of up to ten business days.

Notice Of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (Print):_____

Relationship to Patient:_____

Signature:_____ Date:_____

Patient Case History

Chief Concerns:_____
_____
_____
_____

Rate your discomfort on a scale from 1-10 (1 = very little discomfort and 10 = excruciating pain) _____

History of Condition:_____
_____
_____

Associated Symptoms:_____
_____

Aggravating Factors:_____
_____
_____

What has been done to help this condition?_____
_____
_____

Rate the importance of your health on a scale from 1-10 (1 = least important and 10 = most important) _____

Prior Illness, Surgery, Accidents: _____
_____
_____

Family Health History:_____
_____

Other:_____

Name:_____

Date: _____