

Adult Member Health Record

PERSONAL INFORMATION

NAME: _____ (LEGAL FIRST) (Mi) (LEGAL Last)	
ADDRESS: _____ APT NO./SUITE _____	
CITY: _____	STATE/ZIP CODE: _____
HOME PHONE: _____	CELL PHONE: _____
EMAIL ADDRESS: _____	
DATE OF BIRTH: _____	AGE: _____
SOCIAL SECURITY NUMBER: _____	(CIRCLE ONE) MALE FEMALE
MARITAL STATUS: M D/S S W	NUMBER OF CHILDREN: _____
EMPLOYER NAME: _____	
WORK PHONE: _____	TYPE OF WORK: (I.E. PROFESSIONAL, SECRETARIAL, TRADESPERSON, LABORER, HOMEMAKER, STUDENT, RETIRED)

INSURANCE INFORMATION

HEALTH INSURANCE COMPANY NAME (IF APPLICABLE) _____	
NAME OF INSURED: _____	
INSURED DOB _____	INSURED SSN# _____

HEALTH HABITS

DO YOU SMOKE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU DRINK ALCOHOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU WEAR:	<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS	

SUPPLEMENTS YOU TAKE

<input type="checkbox"/> ESSENTIAL FATTY ACIDS/FISH OIL	<input type="checkbox"/> PROBIOTIC
<input type="checkbox"/> MULTIVITAMIN WHICH : _____	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> CALCIUM / MAGNESIUM	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> VITAMIN D	<input type="checkbox"/> OTHER _____

CHIROPRACTIC EXPERIENCE

IS THERE SOMEONE WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? _____	
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING	
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DOCTOR'S NAME: _____	DATE OF LAST VISIT: _____

PAST HEALTH INFORMATION

MAJOR ACCIDENTS OR FALLS CONTRIBUTING TO CURRENT PROBLEM: APPROXIMATE DATE: _____ MRI STUDIES FOR CURRENT PROBLEM? YES NO
DESCRIBE THE REASON FOR YOUR VISIT TODAY: _____
WHEN DID THIS CONCERN BEGIN? _____
HAS THIS CONCERN: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONCERN INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN: _____
HAS THIS CONCERN OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN: _____
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR/THERAPIST NAME: _____
TYPE OF TREATMENT: _____
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT
TYPE OF DISCOMFORT: DULL/ SHARP/ ACHY/ THROBBING/ NUMB/ DEEP
SEVERITY (CIRCLE RANGE) 1 2 3 4 5 6 7 8 9 10= EMERGENCY ROOM
HOW WOULD YOU DESCRIBE THE AMOUNT OF TIME THAT YOU EXPERIENCE THIS CONCERN: CONSTANT (75-100%) FREQUENT (50-75%)
NOTES: _____ _____ _____ _____ _____ _____ _____

ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

GOALS FOR YOUR 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 body. 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 for my condition.**

MEDICATIONS / SUPPLEMENTS

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS (INCLUDING ASPIRIN)
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> VITAMINS:
<input type="checkbox"/> INSULIN	<input type="checkbox"/> SUPPLEMENTS:

YOUR CONCERNS

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

- Thyroid problems
- Sore Throat
- Stiff Neck
- Radiating Arm Pain
- Hand/Finger Numbness
- Asthma
- Allergies
- High Blood Pressure
- Low Blood Pressure
- Heart Murmur
- Pacemaker
- Acid Reflux
- Ulcers

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



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

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

OTHER:

FUNCTIONAL ASSESSMENT ADL

INSTRUCTIONS: Please report any limitations that you are experiencing. Please note that this form is important as it helps us to document Medical Necessity which helps determine whether or not your insurance company is liable for coverage. **DO NOT SKIP OVER**

Check the best statement that applies:

1. Standing

- I can stand as long as I want
- I can stand for 60mins w/out pain
- I can stand 45-60mins w/out pain
- I can stand 20-45mins w/out pain
- I can stand 5-20mins w/out pain
- I am unable to stand w/out pain

2. Sitting

- I can sit as long as wanted w/out pain
- I can sit 6 or more hrs w/out pain
- I can sit 4 or more hrs w/out pain
- I can sit 2 or more w/out pain
- I can sit 1hr w/out pain
- I am unable to sit without pain

3. Walking

- I can walk as long as desired w/out pain
- I can walk 1 or more miles w/out pain
- I can walk 1/2 mi w/out pain
- I can walk 1 block w/out pain
- I can walk 50 feet w/out pain

MAJOR SURGERIES/OPERATIONS: APPENDECTOMY/ TONSILLECTOMY/ GALL BLADDER/ HERNIA/ BACK SURGERY/ BROKEN BONES

OTHER: _____ **Date:** _____

FOR WOMEN ONLY:

ARE YOU PREGNANT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, WHEN IS YOUR DUE DATE?	ARE YOU NURSING?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ARE YOU TAKING BIRTH CONTROL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<u>DO YOU:</u>	EXPERIENCE PAINFUL PERIODS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
			HAVE BREAST IMPLANTS?	HAVE IRREGULAR CYCLES?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

The Road To Wellness

Rate your health

Place an 'X' ON THE DOT-
TED LINE where you be-
lieve your level of health to
be AT THE CURRENT MO-
MENT.

Place an 'O' on the dotted
line indicating where you
would like your health to be
if conditions were to im-
prove.



AUTHORIZATION FOR CARE AND INFORMED CONSENT

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. 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.

As with any health care problem there are certain complications that may arise during chiropractic adjustments and therapy. Soreness as in that experienced following exercise is most common. Dizziness, fractures/joint injury may occur but are extremely rare. Nerve damage or stroke is reported to occur once in one million to once in ten million adjustments. This is comparable to your chance of getting hit by lightning. Your chiropractor will make every reasonable effort to screen for complications of care; but if you have a condition that would not otherwise come to his/her attention, it is your responsibility to inform me. Other treatment options may include; self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalizations and surgery. If you choose one of these options listed you should be aware that there are risks and benefits of such options. The risks of remaining untreated: Remaining untreated may complicate treatment making it more difficult and less effective the longer it is postponed.

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 negative 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.

Do you have any questions regarding the above authorization statement and /or informed consent? () NO () YES, Please explain: _____

SIGN IF READ ABOVE _____ DATE _____ DOCTOR/CA INITIALS: _____

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 its 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 (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE: