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:	
WE USE TEXT MESSAGING FOR APPOINTMENT REMINDERS. WHO IS YOUR CELL PHONE COMPANY?	
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?	❑ YES	❑ NO
DO YOU DRINK ALCOHOL (AVG. 2 OR MORE/WK)?	❑ YES	❑ NO
DO YOU DRINK COFFEE, TEA OR SODA? REGULARLY?	❑ YES	❑ NO
DO YOU EXERCISE REGULARLY? (AT LEAST 3 TIMES PER WEEK)	❑ YES	❑ NO

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):
❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

DOCTOR'S NAME: DATE OF LAST VISIT

FAMILY HEALTH HISTORY

CHECK THE FOLLOWING CONDITIONS UNDER THE APPROPRIATE RELATIVE THAT HAVE BEEN EXPERIENCED IN YOUR FAMILY EITHER PAST OR PRESENT.

RELATIVE	MOTHER	FATHER	SIBLING	GRANDPARENT
CANCER				
HIGH BLOOD PRESSURE				
HEART DISEASE				
STROKE				
BACK PAIN				

MAJOR SURGERIES /

APPENDECTOMY / TONSILLECTOMY / GALL BLADDER / HERNIA / BACK SURGERY /BROKEN BONES

DATES; _____

OTHER: _____

MEDICATIONS/SUPPLEMENTS

❑ CHOLESTEROL MEDICATIONS	❑ BLOOD PRESSURE MEDICINE
❑ PAIN KILLERS	❑ BLOOD THINNERS
❑ MUSCLE RELAXORS	❑ INSULIN
❑ HEART MEDICATIONS	❑ THYROID MEDICINE
❑ ESSENTIAL FATTY ACIDS	❑ PROBIOTICS
❑ VITAMIN D	❑ CALCIUM/MAGNESIUM

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*
__*Stiff Neck*
__*Radiating Arm Pain*
__*Hand/Finger Numbness*
__*Asthma*
__*Allergies*
__*High Blood Pressure*
__*Low Blood Pressure*
__*Headaches*
__*Dizziness*

__*Jaw/TMJ problems*
__*Fatigue*
__*Vision Problems*
__*Hearing Problems*
__*Anxiety*
__*Depression*
__*Fevers/Night sweats*
__*Loss of Strength*

__*Middle Back Pain*
__*Difficulty Breathing*
__*Gallbladder Conditions*
__*Diabetes*
__*Gastritis*
__*Hepatitis/Liver Problems*
__*Kidney Problems*
__*Urinary Tract Infections*
__*Constipation*
__*Colitis*

__*Diarrhea*
__*Ulcers*
__*Irritable Bowel*
__*Menstrual Problems*
__*Low Back Pain*
__*Pain or Numbness in legs*
__*Prostrate dysfunction*
__*Difficulty Urinating*

DOES THE PAIN RADIATE?

❑ RADIATES TO THE RIGHT BUTTOCK/THIGH
❑ RADIATES TO THE LEFT BUTTOCK/THIGH
❑ RADIATES TO THE RIGHT ARM/HAND
❑ RADIATES TO THE LEFT ARM/HAND
❑ OTHER:

NOTES:

PATIENT NAME: _____ DATE: _____

Please note that it's through your input that we are able to document medical necessity for your insurance. This is important because your insurance company may deny coverage for you if we cannot document medical necessity. Please help us by providing as much detail as possible.

1. **Headaches:** YES NO **(If no, skip to # 2)**

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

HOW OFTEN THEY OCCUR: ___ DAILY___ WEEKLY ___ MONTHLY # PER DAY____# PER MONTH ____

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Does the pain radiate? __Yes __No If so where? __To front __To back of head __Behind eyes __To side of head

What makes it better: _____

What makes it worse:_____

2. Neck Pain: YES NO **(If no, skip to # 3)**

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

HOW OFTEN IT OCCURS : ___ DAILY ___ WEEKLY ___ MONTHLY

How would you describe the amount of time that you have neck pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Does the pain radiate? YES NO If yes, where? Upper back___ Right arm/hand___ Left arm/hand ___

What makes it better: _____

What makes it worse: _____

Do you experience tingling or numbness in any of the following areas?

Head/Face Lt arm/Lt Hand Rt arm/Rt hand

3. Mid Back Pain: YES NO **(If no, skip to # 4)**

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

HOW OFTEN IT OCCURS : ___ DAILY ___ WEEKLY ___ MONTHLY

How would you describe the amount of time that you have mid-back pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Does the pain radiate? YES NO If yes, where? Rib area___ Chest area___ Sternum ___ Shooting up/down

What makes it better: _____

What makes it worse: _____

4. Lower Back Pain: YES NO **(If no, skip to # 5)**

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

HOW OFTEN IT OCCURS : ___ DAILY ___ WEEKLY ___ MONTHLY

How would you describe the amount of time that you have mid-back pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Does the pain radiate? YES NO If yes, where? L/R Buttock___ Lt Thigh___ Rt Thigh ___ Lt foot ___Rt foot

What makes it better: _____

What makes it worse: _____

CHECK OFF ANY OF THE FOLLOWING CONDITIONS THAT ANYONE IN YOUR FAMILY HAS EXPERIENCED IN THE PAST **AND LIST THE RELATIVE WHO WAS AFFECTED (CIRCLE ALL THAT APPLY)**

CANCER: Mother / Father/ Sibling /Grandparent Type(s): _____

HIGH BLOOD PRESSURE: Mother / Father/ Sibling /Grandparent

HEART DISEASE: Mother / Father/ Sibling /Grandparent

STROKE: Mother / Father/ Sibling /Grandparent

Please list prior surgeries and years: _____

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 lightening. 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.

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: _____

SIGNATURE OF PARENT OR GUARDIAN IF MINOR CHILD _____ PRINT NAME:_____

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:
Would you like to authorize a family friend to have access to you PHI? (protected health information) YES NO	If yes please state Name of Family Member(s)_____ Signature of Patient: _____

FOR WOMEN ONLY

❑PREGNANT WEEKS_____	❑AMENORRHEA
❑TRYING TO BE PREGNANT	❑BIRTH CONTROL: TYPE_____
❑MENSTRAL CRAMPS	❑PMS

***X-rays may be taken during the exam & x-rays can damage fetal development.**

Signature verifying patient is NOT pregnant:

_____

FOR DOCTORS USE ONLY

CONTRAINDICATIONS FOR ADJUSTMENTS:
ACUTE ARTHROPATHIES **Y / N**
ACUTE FRACTURE/DISLOCATION WITH INSTABILITY **Y / N**
UNSTABLE OS ODONTOIDEUM **Y / N**
MALIGNANCIES IN VERTEBRAL COLUMN **Y / N**
INFECTION OF BONE OF VERTEBRAL COLUMN **Y / N**
SIGNIFICANT MAJOR ARTERY ANEURYSM NEAR AREA OF MANIPULATION **Y / N**

Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

1.) Standing

4	3	2	1	0
Increased pain with any standing	Increased pain after 5 -20 minutes	Increased pain after 20-45 minutes	Increased pain after 1 hour.	No pain after several hours.

2.) Sitting

4	3	2	1	0
Increased pain with any sitting	Increased pain after 1/2 hour.	Increased pain after 1 hour.	Increased pain after several hours.	No pain after several hours.

3.) Walking

4	3	2	1	0
Increased pain with all walking	Increased pain after 1/4 mile	Increased pain after 1/2 mile	Increased pain after 1 mile	No pain any distance

4.) Housework/ Work

4	3	2	1	0
Increased pain with all housework	Increased pain after 5-10 minutes	Increased pain after 20 minutes	Increased pain after 60 minutes	No pain with any housework

5.) Bending

4	3	2	1	0
Cannot bend without pain	No pain bending 10 degrees	No pain bending 50 degrees	No pain bending 80 degrees	No pain when bending

6.) Lifting

4	3	2	1	0
Cannot lift without pain	No pain when lifting light weight	No pain when lifting moderate	No pain when lifting heavy weight	No pain when lifting

7.) Sleeping

4	3	2	1	0
Totally disturbed sleep	Greatly dis-turbed sleep	Moderately disturbed sleep	Mildly disturbed sleep	Non-disturbed sleep

8.) Recreation

4	3	2	1	0
Cannot do any activities	Can do a few activities	Can do some activities	Can do most activities	Can do all activities

9.) Personal Care (washing, dressing, etc.)

4	3	2	1	0
Severe Pain; need 100% assistance	Moderate Pain; need some assistance	Moderate Pain; need to go slowly	Mild pain ; No restrictions	No pain ; No restrictions

10.)Travel (driving, etc.)

4	3	2	1	0
Severe pain on short trips	Moderate pain on short trips	Moderate pain on long trips	Mild pain on long trips	No pain on long trips

DOCTORS USE ONLY

INITIAL FREQUENCY	❑ 3 X A WEEK	❑ 2 X A WEEK	❑ ____ X A WEEK/MONTH	FOR ___ WEEKS/MONTHS
CMT	❑ 1-2 AREAS	❑ 3-4 AREAS		

PAIN INTENSITY GOAL:

SHORT-TERM: TO DECREASE THE BORG SCALE PAIN INTENSITY RATING TO A ____ OUT OF 10
LONG-TERM: TO DECREASE THE BORG SCALE PAIN INTENSITY RATING TO A ____ OUT OF 10

FUNCTIONAL GOAL:

1.SHORT-TERM:FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO ____ .
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)

LONG-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO ____ .
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)

2.SHORT-TERM:FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO ____ .
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)

LONG-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO ____ .
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)