Adult Member Health Record

	ABOUT YOU	CHIROPRACTIC EXPERIENCE		
NAME:		WHO REFERRED YOU TO OUR OFFICE?		
ADDRESS:		HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): □ NEWSPAPER □ SIGN □ YELLOW PAGES □ COMMUNITY EVENT □ MAILING		
СІТҮ:	STATE/ZIP CODE:	HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ☐ YES ☐ NO		
HOME PHONE:	CELL PHONE:	IF YES, WHAT WAS THE REASON FOR THOSE VISITS?		
MAIL ADDRESS:	1 State of the	DOCTOR'S NAME:		
ATE OF BIRTH:	AGE:	APPROXIMATE DATE OF LAST VISIT:		
OCIAL SECURITY NUMBER:	GENDER:	HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?		
MARITAL STATUS:	NUMBER OF CHILDREN:	REASON FOR THIS VIS		
EMPLOYER ADDRESS:	nena simbilinakan kelebahan di melebahan dipenakan kelabahan kenada pendangan Pisaria, kebupat pendangan sebag Pendangan kelabahan dipendangan berangan berangan berangan berangan berangan berangan berangan berangan berang	DESCRIBE THE REASON FOR THIS VISIT:		
WORK PHONE:	POSITION TITLE:			
an mangagi an ang at ang at an ang at ang at an an	on worse? YES NO	☐ WELLNESS ☐ SPORTS ☐ AUTO ☐ FALL. ☐ HOME INJURY		
	ABOUT YOUR SPOUS	WHEN DID THIS CONCERN BEGIN?		
SPOUSE NAME:		DOES MENTAL STRESS SEEM TO AGGREVATE YOUR CONDITION?		
SPOUSE EMPLOYER:		HAS THIS CONCERN:		
OSITION TITLE:		DOES THIS CONCERN INTERFERE WITH:		
	HEALTH HABIT	□ WORK □ SLEEP □ DAILY ROUTINE □ OTHER ACTIVITIES PLEASE EXPLAIN:		
OO YOU SMOKE?	es 🗆 NO	HAS THIS CONCERN OCCURRED BEFORE? YES NO		
O YOU DRINK ALCOHOL? YE		PLEASE EXPLAIN:		
O YOU DRINK COFFEE, TEA OR		HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? ☐ YES ☐ NO		
DO YOU WEAR:		DOCTOR'S NAME:		
□ HEEL LIFTS □ SOLE LIFTS □ INNER SOLES □ ARCH SUPPORTS		TYPE OF TREATMENT:		
		RESULTS: □ GOOD □ BAD □ INDIFFERENT		
M	EDICATIONS YOU TAKE	SUPPLEMENTS YOU TA		
□ CHOLESTEROL MEDICATION	IS INSULIN	☐ ESSENTIAL FATTY ACIDS ☐ PROBIOTIC		
□ STIMULANTS	□ PAIN KILLERS	□ MULTIVITAMIN □ OTHER		
□ TRANQUILIZERS	□ BLOOD PRESSURE MEDICINE	WHICH: OTHER		
■ MUSCLE RELAXERS	□ OTHER	D VITAMING D OTHER		

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

ARE 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 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.

YOUR CONCERNS

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

Constipation Colitis Diarrhea Gas Pain

Irritable Bowel

Bladder Problems

Menstrual Problems Low Back Pain

Pain or Numbness in legs

Reproductive Problems

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

T2

T4

T5

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

OTHER:

HEALTH CONDITIONS.

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.

□ SEVERE OR FREQUENT HEADACHES	☐ THYROID PROBLEMS	PAIN IN ARMS/LEGS/ HANDS	□ NUMBNESS	FOR WOMEN ONLY:
□ HEART SURGERY/ PACEMAKER	□ SINUS PROBLEMS	□ LOW BLOOD PRESSURE	□ ALLERGIES	ARE YOU PREGNANT? ☐ YES ☐ NO
□ LOWER BACK PROBLEMS	□ HEPATITIS	□ RHEUMATIC FEVER	□ DIABETES	IF YES, WHEN IS YOUR DUE DATE?
□ DIGESTIVE PROBLEMS	DIFFICULTY BREATHING	□ ULCERS/COLITIS	□ SURGERIES:	ARE YOU NURSING? □ YES □ NO
□ PAIN BETWEEN SHOULDERS	□ KIDNEY PROBLEMS	□ TUBERCULOSIS	□ ASTHMA	ARE YOU TAKING BIRTH CONTROL? □ YES □ NO
CONGENITAL HEART DEFECT	□ HIGH BLOOD PRESSURE	□ ARTHRITIS	□ LOSS OF SLEEP	DO YOU: EXPERIENCE PAINFUL PERIODS? HAVE IRREGULAR CYCLES? YES NO
□ FREQUENT NECK PAIN	□ CHEMOTHERAPY	□ SHINGLES	□ DIZZINESS	HAVE IRREGULAR CYCLES? HAVE BREAST IMPLANTS?

SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

INFO	RMED CONSENT FOR C	HIROPRACTIC TRE	ATMENT
limited to, fractures, disc injuries, stro	kes, dislocations and sprains. tor to exercise judgment durin	I do not expect the do	e some risks to treatment, including and not ctor to anticipate and explain all risks and lure which the doctor feels at the time, based
By signing below I agree to the above cover the entire course of my treatment.	and allow the doctor, affiliate	d with Chin	opractic, to perform such. This consent wil
Patient Name:	AND AND SELECTION	Meenmere	Date:
Patient or Guardian Signature:			. Date:
		ION FOR CARE	
I clearly understand and agree that all I agree that I am responsible for all l	l services rendered me are cha bills incurred at this office. Th cal diagnosis. I also understan	rged directly to me and the he Doctor will not be held	my spine, as he or she deems appropriate. at I am personally responsible for payment. I responsible for any pre-existing medically ninate my care, any fees for professional ser-

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.

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.

SIGN IF READ ABOVE		DATE
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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: