PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name____

Address____

City_____________________________ State______________

Zip ________________Home phone ____________________

Birth date ______________ Cell Phone___________________

Age __________ Gender _________ Number of children ______

Employer_______________________________________

Work phone _____________________________________

Type of work ____________________________________

Marital Status ______Spouse's Name____________________

Social Security # _________________________________

E-mail address_____________________________________

How may we reach you ? ☐ Home ☐ Cell phone ☐ Work

Check all that apply

ABOUT THE PRIMARY INSURED

Name _____________________________________

Employer __________________________________

Birthdate __________________________________

SS# _______-______-_________

REASON FOR THIS VISIT

Describe the purpose of this visit ___________________________

____

Is the purpose of this appointment related to:

☐ Job ☐ Sports ☐ Auto ☐ Wellness ☐ Fall

☐ Home Injury ☐ Chronic Discomfort ☐ Other

Please explain ______________________________________

If job related, have you made a report of you 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 ___________________________________

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office?_____________________________

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

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

Reason for those visits? ______________________________

Doctor's name:______________________________________

Approximate date of last visit:_______________________________

Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No

HEALTH HABITS

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

Do you wear:

☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

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

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ☐ Yes ☐ No

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.

C1–C4: Headaches, Migraines - Dizziness, Sinus Problems -Allergies, Fatigue - Head Colds, Vision Problems, Difficulty Concentrating, Hearing Problems

C5–T1: Sore Throat - Stiff Neck, Radiating Arm Pain, Hand/Finger Numbness, Asthma –Allergies, High Blood Pressure, Heart Conditions

T2–T12: Middle Back Pain, Congestion, Difficulty Breathing, Bronchitis - Pneumonia, Gallbladder Conditions, Stomach Problems, Ulcers - Gastritis, Kidney Problems

L1–Sacral: Constipation - Colitis, Diarrhea - Gas Pain, Irritable Bowel, Bladder Problems, Menstrual Problems, Low Back Pain, Pain or Numbness in legs, Reproductive Problems

Other:______________

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 my condition.**

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:______________________
____

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has 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 not being accepted for care.

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

Do you have breast implants? ☐ Yes ☐ No

- ☐ Severe or frequent headaches
- ☐ Sinus problems
- ☐ Dizziness
- ☐ Loss of sleep
- ☐ Pain between shoulders
- ☐ High/Low blood pressure
- ☐ Frequent neck pain
- ☐ Numbness in Arms/legs/hands
- ☐ ☐ Asthma
- ☐ Lower back problems
- ☐ Heart surgery/pacemaker
- ☐ Heart attack/stroke
- ☐ Heart murmur
- ☐ Congenital heart defect
- ☐ Chemotherapy
- ☐ Difficulty breathing
- ☐ Tuberculosis
- ☐ Alcohol/drug abuse Other
- ☐ Rheumatic fever
- ☐ HIV/AIDS
- ☐ Arthritis
- ☐ Shingles
- ☐ Kidney problems
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Hepatitis
- ☐ ___________
- ☐ ___________

AUTHORIZATION FOR CARE

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.

Signature ______________________ Date ______________

Guardian's Signature Authorizing Care (If patient is under 18 years of age) ______________________ Date ______________

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.

Terms Of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

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 adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain optimal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a 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 of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, ______________________________ have read and fully understand the above statement.

Any 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 this basis.

Patient's Signature

____ Date ____________________

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 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 physicians 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:____________________

FOR DOCTOR USE ONLY

Patient Case History

Chief Concerns:____

____

____

____

History of Condition:____

____

____

Associated Symptoms:____

____

Aggravating Factors:____

____

____

What has been done to help this condition?____

____

____

____

Prior Illness, Surgery, Accidents: ____

____

____

Family Health History:____

____

Other:____

Dr signature____