

Adult Member Health Record

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
COMMUNICATION PREFERENCE: PLEASE CIRCLE OPTION	PHONE MAIL EMAIL
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	GENDER:
MARITAL STATUS:	SPOUSE NAME:
EMPLOYER NAME:	
EMPLOYER ADDRESS/CITY/STATE/ZIP:	
WORK PHONE:	POSITION TITLE:
EMERGENCY CONTACT:	EMERGENCY PHONE:

PRIMARY CARE PROVIDER

PROVIDER NAME:
PROVIDER ADDRESS:
CITY/STATE/ZIP:
PHONE:

HEALTH INSURANCE

INSURED'S NAME:	DOB:
INSURANCE COMPANY:	
MEMBER ID:	

HEALTH HABITS

DO YOU SMOKE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, how much per day _____
DO YOU DRINK ALCOHOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, how much per week _____
HEIGHT _____	WEIGHT _____		
DOMINANT HAND	R _____	L _____	
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		

CHIROPRACTIC EXPERIENCE

WHO REFERRED 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
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> JOB <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

MEDICATIONS YOU TAKE

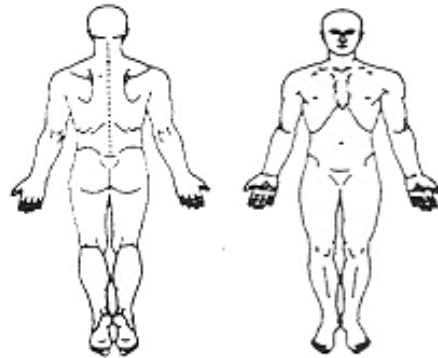
<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS (INCLUDING ASPIRIN)
<input type="checkbox"/> MUSCLE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

HEALTH HISTORY

	SELF	FAMILY		SELF	FAMILY
SEVERE OR FREQUENT HEADACHE			THROID PROBLEMS		
HEART SURGERY/ PACEMAKER			SINUS PROBLEMS		
LOW BACK PROBLEMS			HEPATITIS		
DIGESTIVE PROBLEMS			DIFFICULTY BREATHING		
PAIN BETWEEN SHOULDERS			KIDNEY PROBLEMS		
HEART DEFECTS			HIGH BLOOD PRESSURE		
FREQUENT NECK PAIN			CHEMOTHERAPY		
PAIN IN ARMS/ LEGS			NUMBNESS		
LOW BLOOD PRESSURE			ALLERGIES		
RHEUMATIC FEVER			DIABETES		
ULCERS/COLITIS			SURGERIES		
TUBERCULOSIS			ASTHMA		
ARTHRITIS			LOSS OF SLEEP		
SHINGLES			DIZZINESS		

INSTRUCTIONS: BY USING THE KEY BELOW, INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING THE FOLLOWING SYMPTOMS:

- # = NUMBNESS X = BURNING
 / = STABBING 0 = PINS & NEEDLES
 + = DULL ACHE



Using a scale in which "0" is none (no pain or symptoms) and 10 is severe pain or symptoms circle the number that best reflects your condition:

none.....to.....severe

0 1 2 3 4 5 6 7 8 9 10

FOR WOMEN ONLY:

ARE YOU PREGNANT OR PLANNING TO BE? IF YES WHEN ARE YOU DUE?	YES	NO
ARE YOU TAKING BIRTH CONTROL?	YES	NO
DO YOU: EXPERIENCE PAINFUL PERIODS?	YES	NO
HAVE IRREGULAR CYCLES?	YES	NO
HAVE BREAST IMPLANTS?	YES	NO

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.

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.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?
 PATIENT SPOUSE PARENT WORKERS COMP AUTO INSURANCE MEDICARE INSURANCE

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 only when the patient understands both the objective and the method that they 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 maximum 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.

SIGNATURE:

DATE:

WITNESS 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 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.

NAME OF INDIVIDUAL YOU ARE GRANTING PERMISSION

RELATIONSHIP TO PATIENT:

PATIENT NAME (PLEASE PRINT):

PHONE NUMBER OF INDIVIDUAL ABOVE:

SIGNATURE:

DATE: