

Adult Member Health Record

ABOUT YOU

FIRST NAME:		MIDDLE INITIAL:	
LAST NAME:			
ADDRESS:			
CITY:		STATE/ZIP CODE:	
HOME PHONE:		CELL PHONE:	
EMAIL ADDRESS:			
DATE OF BIRTH:		AGE:	
SOCIAL SECURITY NUMBER:		GENDER:	
MARITAL STATUS:		NUMBER OF CHILDREN:	
EMPLOYER:			
WORK PHONE:		POSITION TITLE:	
ARE YOU: <input type="checkbox"/> A STUDENT <input type="checkbox"/> A MEMBER OF THE MILITARY			

ABOUT YOUR FAMILY

SPOUSE NAME:
KIDS NAMES AND AGES:

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

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> WEBSITE <input type="checkbox"/> FRIEND: _____ <input type="checkbox"/> OTHER: _____
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?
PREVIOUS CHIROPRACTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. <u>IF YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE.</u> <input type="checkbox"/> WELLNESS <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> JOB <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
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'S NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT

SUPPLEMENTS YOU TAKE

<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<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 C	<input type="checkbox"/> OTHER _____

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

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

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.

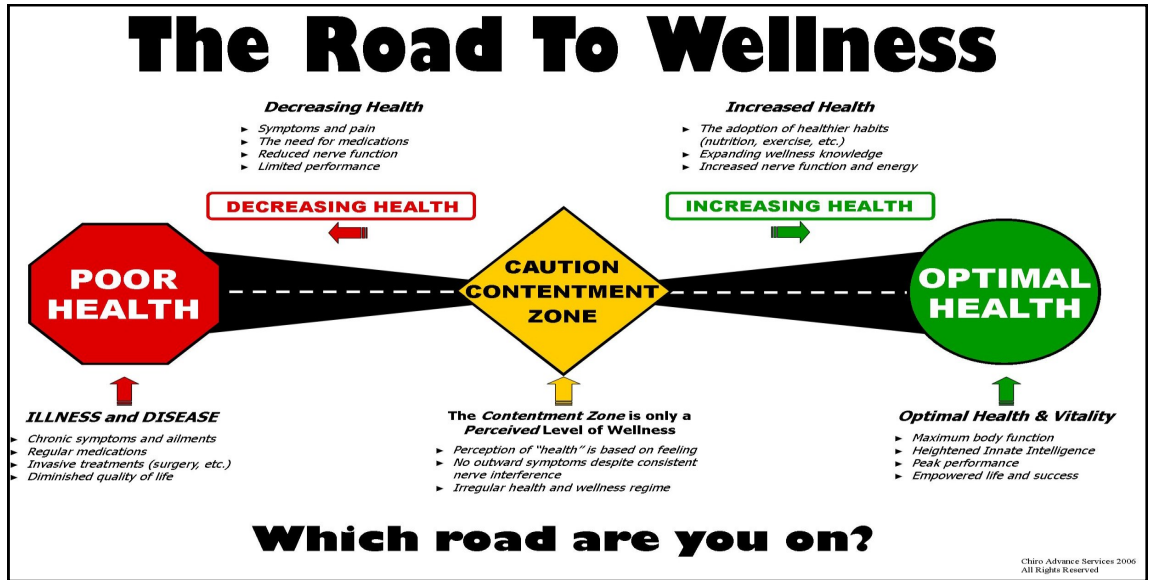
<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS	<input type="checkbox"/> NUMBNESS	FOR WOMEN ONLY:
<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/>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

SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

Rate your health

Place an 'X' that denotes where you believe your current level of health to be.

Place an 'O' indicating where you would like your health to be.



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 understand that this office does not bill insurance nor take assignment for insurance coverage. 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, if applicable, and that all fees for services rendered are due at date of service.

Ownership of X-rays: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray file 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 _____

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 (If patient is a minor):
SIGNATURE:	DATE:

Health Status Questionnaire

YOUR PHYSICAL LIFE

Rate based on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly

Presence of physical neck/backache pain, headaches...	1	2	3	4	5	Incidence of nausea, diarrhea or constipation	1	2	3	4	5
Feelings of tension, stiffness, lack of flexibility.	1	2	3	4	5	Incidence of allergies, eczema, or skin rash.	1	2	3	4	5
Incidence of fatigue or low energy.	1	2	3	4	5	Incidence of dizziness or lightheadedness.	1	2	3	4	5
Incidence of colds or flu.	1	2	3	4	5	Inability to work out or engage in activity.	1	2	3	4	5

MENTAL/EMOTIONAL STATE

Rate based on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly

Presence of negative feelings or negative energy.	1	2	3	4	5	Being overly worried about small things.	1	2	3	4	5
Moodiness, temper, or angry outbursts.	1	2	3	4	5	Difficulty thinking or concentrating.	1	2	3	4	5
Difficulty falling or staying asleep.	1	2	3	4	5	Feelings of depression or anxiety.	1	2	3	4	5

STRESS EVALUATION

Rate based on how the level of stress these areas cause you. 1= None 2= Rare 3= Occasional 4= Regular 5= Constant

Family	1	2	3	4	5	Work/School	1	2	3	4	5
Significant relationships	1	2	3	4	5	General well-being	1	2	3	4	5
Health	1	2	3	4	5	Emotional well-being	1	2	3	4	5
Finances	1	2	3	4	5	Coping with daily problems	1	2	3	4	5

LIFE ENJOYMENT

Rate based on the level of enjoyment experienced. 1= Extensive 2= Considerable 3= Moderate 4= Slight 5= None

Experiences of relaxation, ease, or well-being.	1	2	3	4	5	Compassion and acceptance of others.	1	2	3	4	5
Interest in maintaining a healthy lifestyle, diet, etc.	1	2	3	4	5	The level of recreation in your life.	1	2	3	4	5
Confidence in your ability to deal with adversity.	1	2	3	4	5	Time devoted to things you enjoy.	1	2	3	4	5

OVERALL QUALITY OF LIFE

Rate based on the level of enjoyment experienced. 1= Delighted 2= Mostly Satisfied 3= Mixed 4= Dissatisfied 5= Unhappy

Your personal life.	1	2	3	4	5	The handling of the problems in your life.	1	2	3	4	5
Your spouse/significant other.	1	2	3	4	5	Your physical appearance.	1	2	3	4	5
Your job and the work you do.	1	2	3	4	5	The way you adjust to changes in your life.	1	2	3	4	5



Health Goals

Of the many aspects of your life, where does your health and wellness rate as a priority (1 is highest and 5 is lowest):

1 2 3 4 5

So that we may exceed your expectations, please rate each area below based on their importance to you (1 is high priority, 5 is low):

_____ Money _____ Value _____ Time _____ Service _____ Results

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

NAME: _____ DATE: _____

