

PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name _____
 Address _____ Apt# _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Social Security# _____ Age _____
 Birth Date: _____ Height _____ Weight _____
 Marital Status M S W D # of children _____
 Employer _____
 Work address _____ Work phone _____
 Type of work _____
 What is your physical activity at work?
 Heavy Light
 Sitting (more than 50%) Mod-erate
 Which phone number would you prefer we use?
 Home Cell Work

REASON FOR THIS VISIT

Describe the purpose of this visit _____

 Is this visit related to:
 Job Sports Auto Fall Wellness
 Home Injury Chronic Discomfort Other
 Please explain _____
 If job related, have you made a report of your 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 _____
 Results _____

ABOUT THE PARTNER

Name _____
 Employer _____
 Work phone _____
 Type of work _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____
 Have you seen us advertised? Yes No
 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
 Has any child in your family seen a Chiropractor? Yes No

HEALTH HABITS

	No	Yes
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Is your diet generally healthy?	<input type="checkbox"/>	<input type="checkbox"/>
What type of regular exercise do you perform?		
<input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous		
Please Describe _____		

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
- Chiropractic is the largest natural healing profession in the world? Yes No
- Chiropractic is safe and effective for children and pregnant women? Yes No

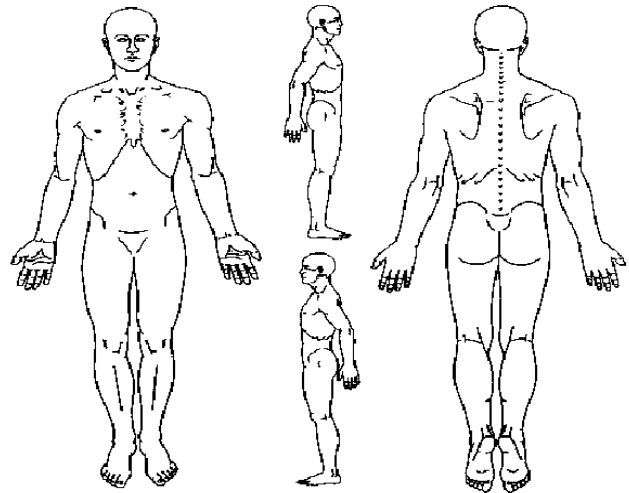


GOALS FOR MY CARE

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.**

Please 'Mark' The Area(s) Of Concern



MEDICATIONS I NOW TAKE...

- | | |
|---|---|
| <input type="checkbox"/> Cholesterol Medication | <input type="checkbox"/> Blood Pressure Medication |
| <input type="checkbox"/> Stimulants | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Sleep Aids | <input type="checkbox"/> Pain killers (including aspirin) |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Hormonal Replacement |

Vitamins & Supplements I now take: _____

- | | | | |
|------------------------------------|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Cramps | <input type="checkbox"/> Tingling | <input type="checkbox"/> Extreme Tightness |

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have had now or 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.

For women:

- | | | | | |
|---|--|---|--|---|
| Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Arthritis |
| Are you nursing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Shingles |
| Are you taking birth control pills? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney problems |
| Do you experience painful periods? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Diabetes |
| Do you have irregular cycles? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Thyroid problems |
| Do you have breast implants? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis |
| Are you still getting your period? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Unexplained weight gain/loss | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Tuberculosis |
| Did you or are you experiencing back and/or leg pain during your pregnancy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Numbness in Arms/legs/hands | <input type="checkbox"/> Alcohol/drug abuse | Other: _____ |
| | | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic fever | _____ |
| | | <input type="checkbox"/> Lower back problems | <input type="checkbox"/> HIV/AIDS | _____ |
| | | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Ulcers/Colitis | |

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. All accounts not paid within 90 days will *automatically* be put through on your credit card.

MasterCard Visa American Express Card # _____ Exp. Date _____

Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Who should receive bills for payment on your account?

Patient Spouse Parent Worker's Comp Auto Insurance Medicare Health 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 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 maximal 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 reduce interference to the expression of the body's innate intelligence. Our only method is specific adjusting to correct vertebral subluxations.

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 _____

Witness _____

Patient Case History Cont.

Are there any associated symptoms (headaches, pain with breathing, muscle weakness) _____

Are there any aggravating factors that you are aware of _____

What has been done to help this condition _____

Please describe any prior illnesses, surgeries, injuries _____

Family health history (diabetes, cancer, heart disease) _____

How would you grade your general stress level (select one) Low Moderate Severe
Please explain _____

Please include anything you think might help us to better understand your condition _____

...thank you

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 hat 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: _____