

# ADULT HEALTH RECORD

## ABOUT YOU

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE/ZIP: \_\_\_\_\_

PRIMARY PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GENDER: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

PAYMENT METHOD:  CASH  CHECK  CREDIT CARD

TEXT REMINDERS  EMAIL REMINDERS

## EMERGENCY CONTACT

NAME AND PHONE NUMBER AND RELATIONSHIP: \_\_\_\_\_

## HEALTH HABITS

DO YOU SMOKE?  YES  NO

DO YOU DRINK ALCOHOL?  YES  NO

DO YOU DRINK COFFEE, TEA, OR SODA?  YES  NO

DO YOU EXERCISE REGULARLY?  YES  NO

DO YOU WEAR:

HEEL LIFTS  SOLE LIFTS  INNER SOLES  ARCH SUPPORTS

## MEDICATIONS YOU TAKE

CHOLESTEROL MEDICATIONS  INSULIN

STIMULANTS  PAIN KILLERS

TRANQUILIZERS  BLOOD PRESSURE

MUSCLE RELAXERS  OTHER

## SUPPLEMENTS YOU TAKE

ESSENTIAL FATTY ACIDS  PROBIOTIC

MULTIVITAMIN  OTHER \_\_\_\_\_

WHICH: \_\_\_\_\_  OTHER \_\_\_\_\_

CALCIUM/MAGNESIUM  OTHER \_\_\_\_\_

VITAMIN C

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

HAVE YOU BEEN SEEN BY A CHIROPRACTOR BEFORE?

YES  NO

IF YES, WHAT WAS THE REASON FOR THE VISITS? \_\_\_\_\_

DOCTOR'S NAME: \_\_\_\_\_

APPROXIMATE DATE OF LAST VISIT: \_\_\_\_\_

HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

YES  NO

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: \_\_\_\_\_

BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. \_\_\_\_\_

WELLNESS  SPORTS  AUTO  HOME INJURY  JOB

CHRONIC DISCOMFORT  OTHER

PLEASE EXPLAIN: \_\_\_\_\_

WHEN DID THIS CONCERN BEGIN? \_\_\_\_\_

HAS THIS CONCERN:

GOTTEN WORSE  STAYED CONSTANT  COMES AND GOES

DOES THIS CONCERN INTERFERE WITH:

WORK  SLEEP  DAILY ROUTINE  OTHER ACTIVITIES

PLEASE EXPLAIN: \_\_\_\_\_

HAS THIS CONCERN OCCURRED BEFORE?  YES  NO

PLEASE EXPLAIN: \_\_\_\_\_

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN?  YES  NO

DOCTOR'S NAME: \_\_\_\_\_

TYPE OF TREATMENT: \_\_\_\_\_

RESULTS:  GOOD  BAD  INDIFFERENT

# ADULT HEALTH RECORD

## 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 to 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 the patient. 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.

**Missed Appointments: I agree to prepay for my visits after missing 3 appointments.**

INITIAL IF READ ABOVE \_\_\_\_\_

## 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.*

INITIAL IF READ ABOVE \_\_\_\_\_

## 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. 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: \_\_\_\_\_

# ADULT HEALTH RECORD

## WOMEN ONLY

ARE YOU PREGNANT?  YES  NO  UNSURE

IF YES, WHEN IS YOUR DUE DATE? \_\_\_\_\_

ARE YOU NURSING?  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

## 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 symptoms.
- 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 concerns.*

## 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

**YOUR CONCERNS:** Please circle any concerns in the diagram below.

*Sore Throat*

*Stiff Neck*

*Radiating Arm Pain*

*Hand/Finger Numbness*

*Asthma*

*Allergies*

*High Blood Pressure*

*Heart Conditions*

C1

C2

C3

C4

C5

C6

C7

T1

T2

T3

T4

T5

T6

T7

T8

T9

T10

T11

L1

L2

L3

L4

L5

S

A

C

R

A

*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:**

---



---



---