ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
RACE/ ETHNICITY:	GENDER:
LANGUAGE:	MARRIAGE STATUS:
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD	

ABOUT YOUR FAMILY

SPOUSE NAME:
SPOUSE EMPLOYER:
NAME /AGE OF CHILDREN:

HEALTH HABITS

DO YOU SMOKE?	❑ YES	❑ NO	If yes, how much per day_____
DO YOU DRINK ALCOHOL?	❑ YES	❑ NO	If yes, how much per week_____
DO YOU DRINK COFFEE, TEA, OR SODA			If yes, how much per day_____
DO YOU EXERCISE REGULARLY (3x weekly)?	❑ YES	❑ NO	

EATING HABITS (Check all that apply)
❑ HEALTHY, WELL BALANCED ❑ ORGANIC ❑ HORMONE FREE
❑ MIX OF HEALTHY AND PROCESSED FOODS
❑ MOSTLY PROCESSED, FEW WHOLE FOODS ❑ EAT OUT OFTEN
❑ DIETING

❑ FOOD ALLERGIES/ SENSITIVITES_____

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):
❑ WEBSITE ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ REFERRAL

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES DATE OF LAST VISIT?_____ ❑ NO

WHAT ARE YOUR GOALS AT MIND, BODY & SPIRIT CHIROPRACTIC?
(CHECK ALL THAT APPLY)

_____CHIROPRACTIC CARE _____ MASSAGE THERAPY

_____ FOOD ALLERGY TESTING/CONSULT _____ NUTRITIONAL ASSESMENT

_____ HORMONE HEALTH CONSULT _____CUSTOM FIT ORTHOTICS

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT :

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ JOB ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY
❑ CHRONIC DISCOMFORT ❑ OTHER

DATE THE COMPLAINT BEGAN: _____/_____/_____

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER?
❑ YES ❑ NO

RATE PAIN ON SCALE OF 1 TO 10 (circle the appropriate number):
1 (no pain) 2 3 4 5 (moderate) 6 7 8 9 10 (extreme)

HAS THIS CONDITION:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

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:

TYPE OF TREATMENT AND RESULTS:

HAVE YOU HAD ANY SPECIAL TESTS FOR THIS CONDITION, X-RAY, MRI, EKG, BLOOD WORK, ETC?

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 HELPS NATURALLY TURN BREECH BABIES, HELPS CHILDREN AND BABIES SLEEP BETTER, BE CALM, IMPROVES DIGESTION, CONCENTRATION, DEVELOP HEALTHY POSTURE , AND PREVENT INJURY?
❑ 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 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***

MEDICATIONS YOU TAKE

❑ CHOLESTEROL MEDS	❑ BLOOD PRESSURE MEDS
❑ ADHD MEDS	❑ BLOOD THINNERS
❑ DEPRESSION OR ANXIETY MEDS	❑ PAIN KILLERS
❑ HEARTBURN OR REFLUX MEDS	❑ HYPOTHYROID MEDS
❑ INSULIN OR DIABETIC	❑ OTHER:

❑ VITAMINS, SUPPLEMENTS & HERBALS:

LIST ALLERGIES TO MEDS:_____

❑ **NO KNOWN ALLERGIES TO MEDS**

YOUR CONCERNS

INSTRUCTIONS: *Please* ***circle*** *the health concerns or conditions you may be experiencing now or have in the past. Each area of concern relates to an area of the spine and nerve function.*

Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Thyroid Disease
High Blood Pressure
Heart Conditions
Irregular Heartbeat

Headaches
Migraines
Dizziness
Hearing Problems
Sinus Problems
Sore Throat
Allergies
Depression or Anxiety
Decreased Immunity
Vision Problems
Difficulty Sleeping

Middle Back Pain
Scoliosis
Difficulty Breathing
Reflux
Gallbladder Conditions
Stomach Problems
Ulcers
Liver Problems
High Cholesterol
Kidney Problems

Constipation
Diarrhea
Excess Gas or Bloating
Digestive Problems
Poor Circulation
Bladder Problems
Menstrual Problems
Menopause
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:
❑ AORTIC ANUERYSIM
❑ BRAIN ANUERYSM
❑ PACE MAKER
❑ STROKE
❑ HEPATITIS
❑ _____CANCER
❑ PARKINSON'S
❑ OSTEOARTHRITIS
❑ RHEUMATOID
❑ OSTEOPOROSIS
❑ MS
❑ EXTREME WEIGHT LOSS/GAIN
❑ FATIGUE
❑ TUBERCULOSIS
❑ FIBROMYALGIA
❑ DIABETES
❑ _____

HEALTH CONDITIONS

SURGERIES	FAMILY HISTORY M=Mother F=Father	TRAUMA	FOR WOMEN ONLY:
SURGERY: YEAR:	❑ HEART DISEASE M / F	❑ CAR ACCIDENT YEAR:	ARE YOU PREGNANT? ❑ YES, *DUE*: ❑ NO DIFFICULTY GETIING PREGNANT? ❑ YES ❑ NO
SURGERY: YEAR:	❑ STROKE M / F	❑ FALL YEAR:	REGULAR MAMMOGRAMS ❑ YES ❑ NO REGULAR BREAST EXAMS ❑ YES ❑ NO REGULAR PAP/PELVIC EXAMS ❑ YES ❑ NO
SURGERY: YEAR:	❑ CANCER M / F TYPE:_____	❑ SPORTS INJURY YEAR:	MENOPAUSE SYMPTOMS? ❑ YES ❑ NO EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO HAVE IRREGULAR CYCLES? ❑ YES ❑ NO
SURGERY: YEAR:	❑ AUTOIMMUNE M / F TYPE:_____	❑ _____ YEAR:	**ANY OTHER HEALTH CONCERN YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT?**
SURGERY: YEAR:	❑ _____ M / F	❑ _____ YEAR:	_____ _____ _____
SURGERY: YEAR:	❑ _____ M / F	❑ _____ YEAR:	

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 by phone or email for appointment reminders, announcements, 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.

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.*

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.

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 treat 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. Our objective is to eliminate a major interference to the expression of the body's innate wisdom. Our 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:
CONSENT TO TREAT A MINOR SIGNATURE OF PARENT OR GUARDIAN:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

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G8730	Pos Pain Assess, follow-up plan	G8731	Neg Pain Assess, no plan	G8539	Func Assess, care plan	G8542	Func Assess, no def, no plan
G8939	Pos Pain Assess, no plan/ineligible	G8442	Not Eligible/dis/emergency	G8543	Func Assess, no plan, no reason	G8942	Func Assess, plan in last 30
G8732	No Pain Assess, no reason given	G8509	Pos Pain Assess, no plan No reason	G8540	No Assess, patient refuses, unable	G854	No Func Assess, no reason