New Practice Member Health Record

Chiropractic FIRST
Redefining Health

Personal Info

Name _____ Date _____

Address _____ Date of Birth _____

City, State Zip _____ Gender _____

Home Phone _____ Marital Status _____

Cell Phone _____ Employer _____

Email _____ Occupation _____

Spouse (Name and Birthday) _____ Anniversary _____

Children (Names and Birthdays) _____ _____

_____ _____

_____ _____

Insurance Info

Health Insurance Carrier _____ Policy # _____

Insured's Name and Birthday _____ Group # _____

Assignment and Release of Benefits:

I, the undersigned, give authorization for care. Additionally, I certify that if I have insurance coverage, I assign directly to Chiropractic FIRST all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

General Info

Whom may we thank for referring you? _____

How have you heard of the office? (Check all that apply)

☐ Friend ☐ Family Member ☐ Physician ☐ Health Club ☐ Location ☐ Web ☐ Workshop/Event ☐ Other

Have you ever been to a chiropractor before? ___ YES ___ NO

If yes, did you have a positive experience? ___ YES ___ NO

If not, please tell us why your experience was not positive . _____

_____

Was your care short-term relief or long-term structural correction? ___ Short term ___ Long term

Are you healthier today than you were five years ago? ___ YES ___ NO

How do you know? _____

If yes, what change did you make to accomplish this? _____

If no, do you have a plan to be healthier five years from now? ___ YES ___ NO

If we can help you develop a health preservation plan, are you interested in hearing those recommendations? ___ YES ___ NO

If there is a need for dietary changes, would you like to know? ___ YES ___ NO

If there is a need for specific exercises, would you like to know? ___ YES ___ NO

If there is a need for detoxification, would you like to know? ___ YES ___ NO

If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance? ___ YES ___ NO

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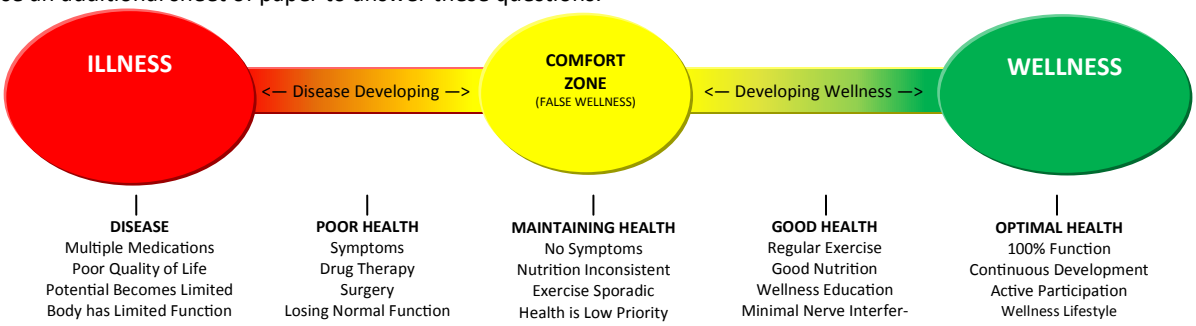
YOUR HEALTH PROFILE

Name: _____ Date: _____

INSTRUCTIONS

Throughout today's exam, your doctor will be searching for one thing: the CAUSE of your health challenge. Chiropractic wellness care seeks to find the causes of a health challenge, rather than simply trying to artificially alleviate the symptoms through chemical manipulation. The following questions *are vital* to finding the cause of your current health condition and its solution. Please take your time answering these questions, including anything that you may feel is related to your current complaints. At Chiropractic FIRST, we have set the bar high and expect nothing but the best results for you. In order to properly begin that process, having a detailed history is a must. So if necessary, please use an additional sheet of paper to answer these questions.



*Please place an "X" above the scale marking where you believe your level of health and wellness is at this time. Please place a circle "O" above where you would **like** your health and wellness to be.*

QUESTIONS

1. Please describe your current health challenge(s). (If you have no symptoms and are here for chiropractic wellness services, please skip to Health History page) _____
   _____
2. What is your goal in consulting the office? _____
   _____
3. When did they begin? _____
4. How did they begin? _____
5. Accident / Injury Involved? ___ YES ___ NO
6. Do you feel your current dietary and exercise habits are related to your health challenge? If so, please explain. _____
7. Do you feel there may be a physical cause related to your health challenge? If so, please explain. _____
   _____
8. Do you feel there may be a mental or emotional component to your personal health challenge? If so, please explain. _____
9. How do you feel your present health challenge affects your overall health and ability to experience an optimal quality of life? _____
10. How would you describe your overall health status prior to this present health challenge? _____
    _____
11. Other than today's presenting complaint, please list any and all concerns regarding your health. _____
    _____
12. What is your medical provider's plan for you to experience optimal health and wellness? _____
    _____

GOALS

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HEALTH QUESTIONNAIRE

Name: _____ Date: _____

HEALTH QUESTIONNAIRE

How often do you experience your reported complaints?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your complaint?

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How are your health complaints changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

During the past 4 weeks, indicate the average intensity of your symptoms:

☐ 0-None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10-Unbearable

During the past 4 weeks, how much of the time has your condition interfered with your normal work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

In general, would you say your overall health right now is…

☐ Excellent ☐ Poor ☐ Very Good ☐ Good ☐ Fair

Who have you seen for your complaint prior to coming here?

☐ No one ☐ Other chiropractor ☐ Medical Doctor ☐ Surgery ☐ Other

What treatment did you receive for your symptoms?

☐ Adjustments ☐ Physical Therapy ☐ Medication ☐ Surgery ☐ Other

When did you receive your last treatment?

☐ In the last month ☐ 2-3 months ago ☐ 3-6 months ago ☐ 6 months to 1 yr ago

☐ 1-2 yrs ago ☐ 2-5 yrs ago ☐ 5-10 yrs ago

Have you experienced your complaints prior to this last reported episode?

Y / N. If Yes, how long ago? _____

What medications have you taken in the past 6 months? *Please indicate what for, and how long:*

_____

_____

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HEALTH HISTORY FORM

CURRENT HEIGHT: **CURRENT WEIGHT:**

MEDICAL HISTORY

ACTIVITIES OF DAILY LIVING

MEDICAL CONDITIONS:

___ Arthritis	___ Acid Reflux	___ Heart Disease	___ Cancer
___Chronic Colds	___ Scoliosis	___ Migraines	___ Diabetes
___Digestive Problems	___ Allergies	___ Skin Disorder	___ Hypertension
	___ Depression	___ Anxiety	___ Psychiatric Illness

PAST SURGERIES: please list any past surgeries and when they were done. _____
_____

ALLERGIES:

___ Eggs	___ Fish and Shellfish	___ Milk or Lactose	___ Peanut
___ Soy	___Sugar	___ Sulfites	___ Wheat / Cluten

SOCIAL HISTORY:

___ Caffeine used occas.	___ Caffeine used often	___ Chew tobacco occas.	___ Chew tobacco often
___ Drink alcohol occas.	___ Drink alcohol often	___ Exercise not at all	___ Exercise occas.
___ Exercise often	___ Stressed occas.	___ Stressed often	___ Smoke 1 pack or less per day
___ Smoke more than 1 pack a day	___ Wear seatbelt often	___ Wear seatbelt never	___ Wear seatbelt usually

FAMILY HISTORY:

___arthritis	___ thyroid	___ allergies	___ high blood pressure
___ cholesterol	___ immune disorder	___ intestinal issues	___ stroke
___ heart problem	___ liver problems	___ cancer	
___ psychiatric	___ asthma	___ diabetes	

CHILD'S HISTORY:

___ asthma	___ hyperactive	___ tonsil issues	___ ADHD
___ allergies	___ trouble concentrating	___ autism	___ headaches/migraines
___ frequent colds	___ digestive issues	___ spectrum disorder	___ learning disabilities
	___ear infections	___ depression	

OCCUPATIONAL ACTIVITIES:

___ Administration	___ Business Owner	___ Clerical	___ Computer user
___ Construction	___ Daycare/childcare	___ Executive/legal	___ Food service industry
___ Health Care	___ Heavy Equipment operator	___ Heavy manual labor	___ Home services
___ Household	___ Light manual labor	___ Manufacturing	___ Med. manual labor
			___ Other

RECREATIONAL ACTIVITIES:

___ backpacking	___ racquetball	___ walking	___ < 60 min a day
___ golf	___ swimming	___ tennis	___ > 60 min a day
___soccer	___ boating	___ gardening	SITTING PER DAY:
___weight lifting	___ running	___ traveling	___ < 1 hour
___ biking	___ tennis	___ other:	___ < 5 hours
	___ football	COMPUTER / T.V. USE:	___ < 12 hours
	___ skiing	___ < 30 min a day	

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Detailed Review of Systems

Patient Name: _____ Date: _____

Cardiovascular:

___ Poor circulation
___ High Blood Pressure
___ Aortic Aneurysm
___ Heart Disease
___ Vascular Disease
___ Heart Attack
___ Chest Pain
___ High Cholesterol
___ Pace Maker
___ Jaw Pain
___ Irregular Heart Beat
___ Swelling of Legs
___ Stroke

Genitourinary:

___ Kidney Disease
___ Lower Side Pain
___ Burning Urination
___ Frequent Urination
___ Blood in Urine
___ Kidney Stone
___ Bed Wetting/Enuresis
___ Prostate Problems

Hematologic/Lymphatic:

___ Hepatitis
___ Blood Clots
___ Cancer
___ Easy Bruising
___ Easy Bleeding
___ Fevers/Chills/Sweats

Respiratory:

___ Asthma
___ Shortness of Breath
___ Upper Respiratory Infec
___ Cold/Flu
___ Pneumonia
___ Cough/Wheezing
___ Emphysema
___ RSV
___ Tuberculosis

Ear/Nose/Throat:

___ Sinus Congestion
___ Sinus Infection
___ Nose Bleed
___ Sore Throat
___ Difficulty Swallowing
___ Ear Ache
___ Ear Infections
___ Dizziness
___ Hearing Loss
___ Bleeding Gums

Eyes:

___ Glaucoma
___ Double Vision
___ Blurred Vision
___ Red, Itchy (allergy)

Integumentary:

___ Eczema
___ Rashes
___ Psoriasis
___ Skin Ulcers
___ Skin Disease

Allergic/Immunologic:

___ Autoimmune Disorder
___ Chronic Allergies
___ Seasonal Allergies
___ Food Allergies
___ Environmental Allergies
___ Allergy Shots
___ Cortisone Use
___ HIV/AIDS
___ Hives

Gastrointestinal:

___ Acid Reflux
___ Bowel Problems
___ Constipation
___ Upset Stomach
___ Gas Pains
___ Ulcers
___ Gallbladder Problems
___ Liver Problems
___ Diarrhea
___ Nausea/Vomiting
___ Poor Appetite
___ Bloody Stools

Musculoskeletal:

___ Poor Posture
___ Neck Pain
___ Back Pain
___ Arthritis
___ Rheumatoid Arthritis
___ Joint Stiffness
___ Muscle Weakness
___ Osteoporosis
___ Broken Bones
___ Joint Replacement
___ Gout

Neurological:

___ Seizures
___ Head injury
___ Brain Aneurysm
___ Numbness/tingling
___ Pinched Nerves
___ Radiating Pain
___ Sciatica
___ Parkinson's Disease
___ Carpal Tunnel
___ Balance/Coordination Problems
___ ADHD/ADD
___Autism/Spectrum dis.
___ Migraine Headaches
___ Sinus Headaches
___ Tension Headaches
___ Vertigo/Dizziness
___ Sensory Integration

Endocrine:

___ Hyperthyroid issues
___ Hypothyroid issues
___ Type 1 Diabetes
___ Type 2 Diabetes
___ Hair Loss
___ Menopausal
___ Menstrual Problems
___ Hot Flashes
___ Endometriosis

Psychiatric:

___ Depression
___ Anxiety Disorder
___ Unusual Stress
___ OCD
___ Bipolar Disorder
___ Seasonal Affective Dis.
___ Social Anxieties

Constitutional:

___ Weight Loss/Gain
___ Energy Level Low
___ Energy Level High
___ Difficulty Sleeping
___ Chronic Fatigue
___ General Malaise
___ Compulsive Behavior
___ Behavior issues
___ Learning Disabilities
___ Speech Delays

Health Assessment Questionnaire

Name: _____ Date: _____

Email Address: _____

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

Physical Health

1. I am a physically fit person and formally exercise on a regular basis.
   1 2 3 4 5 6 7 8 9 10
2. I have a physically attractive body that I am proud to look at in the mirror.
   1 2 3 4 5 6 7 8 9 10
3. I have not had many traumas in my life (auto accident, broken bones, bad falls).
   1 2 3 4 5 6 7 8 9 10
4. I get at least 7 hours of sleep , 7 days a week.
   1 2 3 4 5 6 7 8 9 10
5. I have gotten regular Chiropractic care within the past 5 years.
   1 2 3 4 5 6 7 8 9 10

Total _____

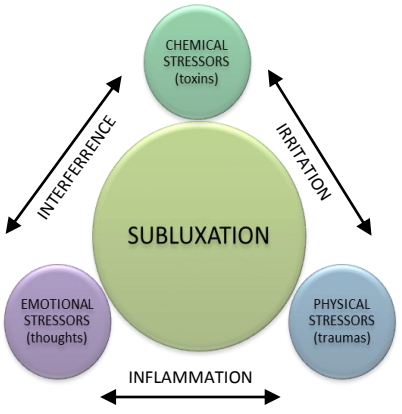
Emotional/Mental Health

1. I am a calm, peaceful person. I an shut my mind off and focus my mind at will.
   1 2 3 4 5 6 7 8 9 10
2. I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.)
   1 2 3 4 5 6 7 8 9 10
3. Most of the time, I am truly happy and feel a sense of purpose in my life.
   1 2 3 4 5 6 7 8 9 10
4. I have healthy relationships and a rich social network of friends and activities.
   1 2 3 4 5 6 7 8 9 10
5. I am organized, have time for myself, and can prioritize the important tasks in my life.
   1 2 3 4 5 6 7 8 9 10

Total _____

Chemical/Nutrional Health

1. I eat 4-6 small meals daily and properly combine my protein, carbs, and fats.
   1 2 3 4 5 6 7 8 9 10
2. I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).
   1 2 3 4 5 6 7 8 9 10
3. I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.
   1 2 3 4 5 6 7 8 9 10
4. I do not smoke cigarettes.
   1 2 3 4 5 6 7 8 9 10
5. I drink water as my primary beverage and consume at least 30 ounces per day.
   1 2 3 4 5 6 7 8 9 10



Total _____

Total of all 3 (physical, emotional, chemical) sections _____