

Adult Member Health Record

PERSONAL INFORMATION

NAME: _____ (LEGAL FIRST) (Mi) (LEGAL Last)	
ADDRESS: _____	APT NO./SUITE _____
CITY: _____	STATE/ZIP CODE: _____
HOME PHONE: _____	CELL PHONE: _____
EMAIL ADDRESS: _____	
WE USE TEXT MESSAGING FOR APPOINTMENT REMINDERS. WHO IS YOUR CELL PHONE COMPANY? _____	
DATE OF BIRTH: _____	AGE: _____
SOCIAL SECURITY NUMBER: _____	(CIRCLE ONE) MALE FEMALE
MARITAL STATUS: M D/S S W	NUMBER OF CHILDREN: _____
EMPLOYER NAME: _____	
WORK PHONE: _____	TYPE OF WORK: (I.E. PROFESSIONAL, SECRETARIAL, TRADESPERSON, LABORER, HOMEMAKER, STUDENT, RETIRED)

INSURANCE INFORMATION

HEALTH INSURANCE COMPANY NAME (IF APPLICABLE) _____	
NAME OF INSURED: _____	
INSURED DOB _____	INSURED SSN# _____

HEALTH HABITS

DO YOU SMOKE? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL (AVG. 2 OR MORE/WK)? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA REGULARLY? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY? (AT LEAST 3 TIMES PER WEEK) _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

YOUR CONCERNS

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.

___ Thyroid problems ___ Stiff Neck ___ Radiating Arm Pain ___ Hand/Finger Numbness ___ Asthma ___ Allergies ___ High Blood Pressure ___ Low Blood Pressure ___ Headaches ___ Dizziness	___ Jaw/TMJ problems ___ Fatigue ___ Vision Problems ___ Hearing Problems ___ Anxiety ___ Depression ___ Fevers/Night sweats ___ Loss of Strength	___ Middle Back Pain ___ Difficulty Breathing ___ Gallbladder Conditions ___ Diabetes ___ Gastritis ___ Hepatitis/Liver Problems ___ Kidney Problems ___ Urinary Tract Infections ___ Constipation ___ Colitis	___ Diarrhea ___ Ulcers ___ Irritable Bowel ___ Menstrual Problems ___ Low Back Pain ___ Pain or Numbness in legs ___ Prostrate dysfunction ___ Difficulty Urinating	DOES THE PAIN RADIATE? <input type="checkbox"/> RADIATES TO THE RIGHT BUTTOCK/THIGH <input type="checkbox"/> RADIATES TO THE LEFT BUTTOCK/THIGH <input type="checkbox"/> RADIATES TO THE RIGHT ARM/HAND <input type="checkbox"/> RADIATES TO THE LEFT ARM/HAND <input type="checkbox"/> OTHER: _____ NOTES: _____ _____
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CHIROPRACTIC EXPERIENCE

IS THERE SOMEONE WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? _____	
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING	
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DOCTOR'S NAME: _____	DATE OF LAST VISIT _____

FAMILY HEALTH HISTORY

CHECK THE FOLLOWING CONDITIONS UNDER THE APPROPRIATE RELATIVE THAT HAVE BEEN EXPERIENCED IN YOUR FAMILY EITHER PAST OR PRESENT.

RELATIVE	MOTHER	FATHER	SIBLING	GRANDPARENT
CANCER				
HIGH BLOOD PRESSURE				
HEART DISEASE				
STROKE				
BACK PAIN				

MAJOR SURGERIES /

APPENDECTOMY / TONSILLECTOMY / GALL BLADDER / HERNIA / BACK SURGERY /BROKEN BONES

DATES: _____

OTHER: _____

MEDICATIONS/SUPPLEMENTS

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> PAIN KILLERS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> MUSCLE RELAXORS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> HEART MEDICATIONS	<input type="checkbox"/> THYROID MEDICINE
<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<input type="checkbox"/> PROBIOTICS
<input type="checkbox"/> VITAMIN D	<input type="checkbox"/> CALCIUM/MAGNESIUM

PATIENT NAME: _____ DATE: _____

Please note that it's through your input that we are able to document medical necessity for your insurance. This is important because your insurance company may deny coverage for you if we cannot document medical necessity. Please help us by providing as much detail as possible.

1. **Headaches:** YES NO (If no, skip to # 2)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

HOW OFTEN THEY OCCUR: ___ DAILY ___ WEEKLY ___ MONTHLY # PER DAY ___ # PER MONTH ___

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Does the pain radiate? ___ Yes ___ No If so where? ___ To front ___ To back of head ___ Behind eyes ___ To side of head

What makes it better: _____

What makes it worse: _____

2. **Neck Pain:** YES NO (If no, skip to # 3)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

HOW OFTEN IT OCCURS : ___ DAILY ___ WEEKLY ___ MONTHLY

How would you describe the amount of time that you have neck pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Does the pain radiate? YES NO If yes, where? Upper back ___ Right arm/hand ___ Left arm/hand ___

What makes it better: _____

What makes it worse: _____

Do you experience tingling or numbness in any of the following areas?

Head/Face Lt arm/Lt Hand Rt arm/Rt hand

3. **Mid Back Pain:** YES NO (If no, skip to # 4)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

HOW OFTEN IT OCCURS : ___ DAILY ___ WEEKLY ___ MONTHLY

How would you describe the amount of time that you have mid-back pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Does the pain radiate? YES NO If yes, where? Rib area ___ Chest area ___ Sternum ___ Shooting up/down

What makes it better: _____

What makes it worse: _____

4. **Lower Back Pain:** YES NO (If no, skip to # 5)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

HOW OFTEN IT OCCURS : ___ DAILY ___ WEEKLY ___ MONTHLY

How would you describe the amount of time that you have mid-back pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Does the pain radiate? YES NO If yes, where? L/R Buttock ___ Lt Thigh ___ Rt Thigh ___ Lt foot ___ Rt foot

What makes it better: _____

What makes it worse: _____

CHECK OFF ANY OF THE FOLLOWING CONDITIONS THAT ANYONE IN YOUR FAMILY HAS EXPERIENCED IN THE PAST AND LIST THE RELATIVE WHO WAS AFFECTED (CIRCLE ALL THAT APPLY)

CANCER: Mother / Father/ Sibling /Grandparent Type(s): _____

HIGH BLOOD PRESSURE: Mother / Father/ Sibling /Grandparent

HEART DISEASE: Mother / Father/ Sibling /Grandparent

STROKE: Mother / Father/ Sibling /Grandparent

Please list prior surgeries and years: _____

AUTHORIZATION FOR CARE AND INFORMED CONSENT

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.

As with any health care problem there are certain complications that may arise during chiropractic adjustments and therapy. Soreness as in that experienced following exercise is most common. Dizziness, fractures/joint injury may occur but are extremely rare. Nerve damage or stroke is reported to occur once in one million to once in ten million adjustments. This is comparable to your chance of getting hit by lightning. Your chiropractor will make every reasonable effort to screen for complications of care; but if you have a condition that would not otherwise come to his/her attention, it is your responsibility to inform me. Other treatment options may include; self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalizations and surgery. If you choose one of these options listed you should be aware that there are risks and benefits of such options. The risks of remaining untreated: Remaining untreated may complicate treatment making it more difficult and less effective the longer it is postponed.

Do you have any questions regarding the above authorization statement and /or informed consent? ()NO ()YES, Please explain: _____

SIGN IF READ ABOVE _____ DATE _____ DOCTOR/CA INITIALS: _____

SIGNATURE OF PARENT OR GUARDIAN IF MINOR CHILD _____ PRINT NAME: _____

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:
SIGNATURE:	DATE:
Would you like to authorize a family friend to have access to you PHI? (protected health information) YES NO	If yes please state Name of Family Member(s) _____ Signature of Patient: _____

FOR WOMEN ONLY

FOR DOCTORS USE ONLY

<input type="checkbox"/> PREGNANT WEEKS _____	<input type="checkbox"/> AMENORRHEA
<input type="checkbox"/> TRYING TO BE PREGNANT	<input type="checkbox"/> BIRTH CONTROL: TYPE _____
<input type="checkbox"/> MENSTRUAL CRAMPS	<input type="checkbox"/> PMS

***X-rays may be taken during the exam & x-rays can damage fetal development.**

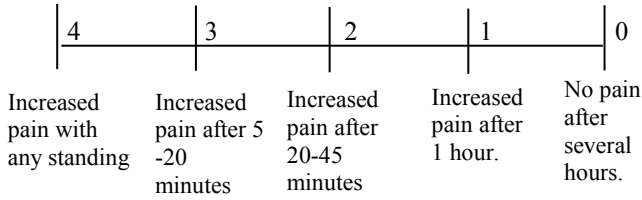
CONTRAINDICATIONS FOR ADJUSTMENTS:
 ACUTE ARTHROPATHIES Y / N
 ACUTE FRACTURE/DISLOCATION WITH INSTABILITY Y / N
 UNSTABLE OS ODONTOIDEUM Y / N
 MALIGNANCIES IN VERTEBRAL COLUMN Y / N
 INFECTION OF BONE OF VERTEBRAL COLUMN Y / N
 SIGNIFICANT MAJOR ARTERY ANEURYSM NEAR AREA OF MANIPULATION Y / N

Signature verifying patient is NOT pregnant:

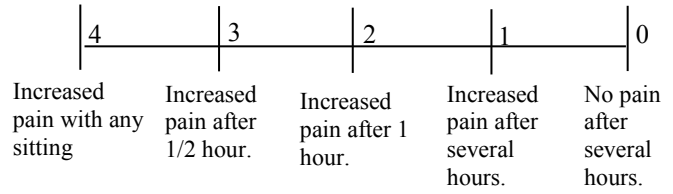
Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck or back problems** have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

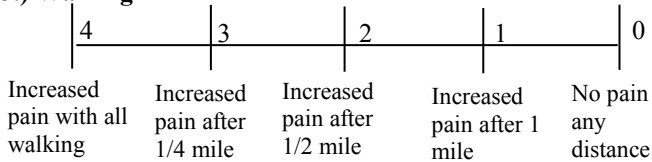
1.) Standing



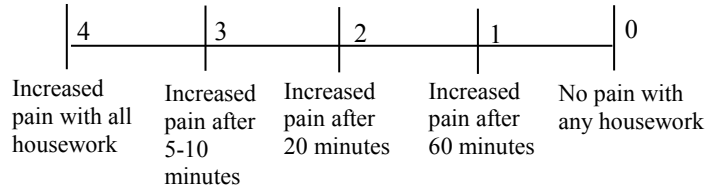
2.) Sitting



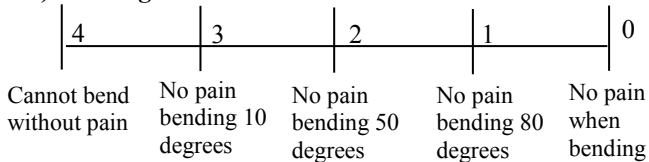
3.) Walking



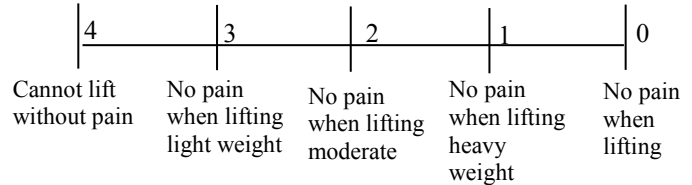
4.) Housework/ Work



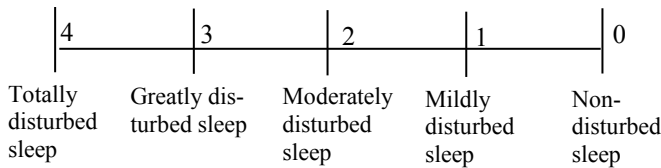
5.) Bending



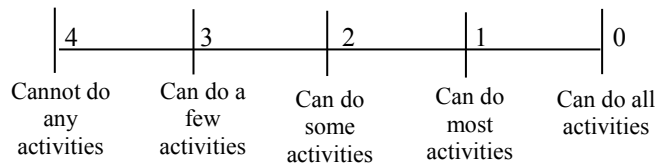
6.) Lifting



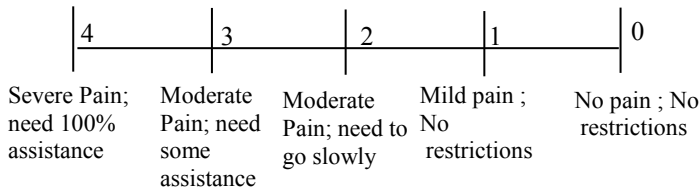
7.) Sleeping



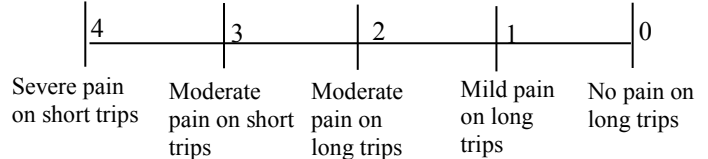
8.) Recreation



9.) Personal Care (washing, dressing, etc.)



10.) Travel (driving, etc.)



DOCTORS USE ONLY

INITIAL FREQUENCY	<input type="checkbox"/> 3 X A WEEK	<input type="checkbox"/> 2 X A WEEK	<input type="checkbox"/> ___ X A WEEK/MONTH	FOR ___ WEEKS/MONTHS
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CMT	<input type="checkbox"/> 1-2 AREAS	<input type="checkbox"/> 3-4 AREAS
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PAIN INTENSITY GOAL:

SHORT-TERM: TO DECREASE THE BORG SCALE PAIN INTENSITY RATING TO A ___ OUT OF 10
 LONG-TERM: TO DECREASE THE BORG SCALE PAIN INTENSITY RATING TO A ___ OUT OF 10

FUNCTIONAL GOAL:

1. SHORT-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO _____
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)

LONG-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO _____
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)

2. SHORT-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO _____
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)

LONG-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO _____
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)