Date: _____

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:

ADDRESS:

CITY: STATE/ZIP CODE:

HOME PHONE: CELL PHONE:

EMAIL ADDRESS:

DATE OF BIRTH: AGE:

MARITAL STATUS: CHILDREN:

EMPLOYER NAME:

EMPLOYER ADDRESS:

WORK PHONE: POSITION TITLE:

INSURANCE COMPANY:

INSURED'S NAME:

INSURED'S DATE OF BIRTH:

ABOUT YOUR SPOUSE

SPOUSE NAME:

ADDRESS:

CITY: ZIP CODE:

HOME PHONE: CELL PHONE:

SPOUSE EMPLOYER NAME:

EMPLOYER ADDRESS: ZIP CODE:

EMPLOYER CITY/SD: POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? ___YES ___NO HOW OFTEN? _____
DO YOU DRINK ALCOHOL? ___YES ___NO HOW OFTEN? _____
DO YOU DRINK COFFEE, TEA, OR SODA? ___YES ___NO

DO YOU EXERCISE REGULARLY? ___YES ___NO
IF YES, HOW OFTEN? _____
IF NO, IS THAT SOMETHING YOU'D LIKE TO IMPROVE? _____

DO YOU WEAR:
___ARCH SUPPORTS
___HEAL LIFTS ___ SOLE LIFTS ___INNER SOLES

Inver Grove chiropractic
2940 65th St. E.
Inver Grove Heights, MN 55076
651-451-1012
61-453-1543 (FAX)

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY):
___NEWSPAPER ___SIGN ___GOOGLE ___MAILING
___COMMUNITY EVENT ___OTHER_____

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ___YES ___NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO :
___SPORTS ___AUTO ___FALL
___CHRONIC DISCOMFORT ___HOME INJURY
___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
___COME AND GONE

DOES THIS CONDITION INTERFERE WITH :
___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:

RESULTS:

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ___YES ___NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ___YES ___NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ___YES ___NO
IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? ___YES ___NO

MEDICATIONS YOU TAKE

___CHOLESTEROL	___BLOOD PRESSURE	___STIMULANTS
___BLOOD THINNERS	___TRANQUILIZERS	___PAIN KILLERS
___ASPIRIN/ETC.	___MUSCLE RELAXERS	___INSULIN
___OTHER	___OTHER	___OTHER

___VITAMINS & SUPPLEMENTS:

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/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
☐ **Full Body:** Chiropractic, Nutrition, Personal Training, etc.

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

C1, C2, C3, C4
HEADACHES
MIGRAINES
DIZZINESS
SINUS PROBLEMS
ALLERGIES
FATIGUE
HEAD COLDS
VISION PROBLEMS
DIFFCULTY CONCENTRATING
HEARING PROBLEMS

C5, C6, C7, T1
SORE THROAT
STIFF NECK
RADIATING ARM PAIN
HAND/FINGER NUMBNESS
ASHTMA
ALLERGIES
HIGH BLOOD PRESSURE
HEART CONDITIONS

T2, T3, T4, T5, T6, T7, T8, T9
MIDDLE BACK PAIN
CONGESTION
DIFFICULTY BREATHING
BRONCHITIS
PNEUMONIA
GALLBLADDER CONDITONS
STOMACH PROBLEMS
ULCERS
GASTRITIS
KIDNEY PROBLEMS

L1, L2, L3, L4, L5, S, A, C, R, A, L
CONSTIPATION
COLITIS
DIARRHEA
GAS PAIN
IRRITABLE BOWEL
BLADDER PROBLEMS
MENSTRUAL PROBLEMS
LOW BACK PAIN
PAIN OR NUMBESS IN LEGS
REPRODUCTIVE

OTHER:
_____
_____
_____
_____

HEALTH CONDITIONS

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 possibility of being accepted for care.*

☐ SEVERE OR FREQUENT HEADACHES	☐ THYROID PROBLEMS	☐ PAIN IN ARMS/LEGS/HANDS	☐ NUMBNESS
☐ HEART SURGERY/PACEMAKER	☐ SINUS PROBLEMS	☐ LOW BLOOD PRESSURE	☐ ALLERGIES
☐ LOWER BACK PROBLEMS	☐ HEPATITIS	☐ RHEUMATIC FEVER	☐ DIABETES
☐ DIGESTIVE PROBLEMS	☐ DIFFICULTY BREATHING	☐ ULCERS/COLITIS	☐ SURGERIES:
☐ PAIN BETWEEN SHOULDERS	☐ KIDNEY PROBLEMS	☐ TUBERCULOSIS	☐ ASTHMA
☐ CONGENITAL HEART DEFECT	☐ HIGH BLOOD PRESSURE	☐ ARTHRITIS	☐ LOSS OF SLEEP
☐ FREQUENT NECK PAIN	☐ CHEMOTHERAPY	☐ SHINGLES	☐ DIZZINESS

FOR WOMEN ONLY:

ARE YOU PREGNANT?
___YES ___NO
IF YES, WHEN IS YOUR DUE DATE? _____
ARE YOU NURSING?
___YES ___NO

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 disclosure for the proposes of treatment, payment, or practice parathion 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 (HIPPA). I have certain right 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 or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

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 subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual finding, 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 question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS SIGNATURE:	DATE:

PAYMENT AGREEMENT/USE OF INSURANCE AUTHORIZATION

I hereby authorize the Doctors of Inver Grove Chiropractic to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by 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. Inver Grove Chiropractic will not be held responsible for any preexisting 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 by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Inver Grove Chiropractic, P.A. 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 Inver Grove Chiropractic 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 Inver Grove Chiropractic, P.A. will be credited to my account upon receipt.

Signature:	Date:
Guardian or Spouse Authorizing Care Signature:	Date:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ WORKERS COMP ☐ AUTO INSURANCE

☐ MEDICARE ☐ HEALTH INSURANCE

Consent to release health information to family and friends. ___ YES ___ NO

I consent to release of my health information by Inver Grove Chiropractic to the following family and friends who are involved in my care or payment for care (identify by name, relationship, and phone number)

_____