PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name_____

Address_____

City_____ State_____

Zip _____Home phone _____

Work Phone _____ Cell Phone_____

Date of Birth _____ Gender ____ Number of children _____

Employer_____

Marital Status _____

Social Security # _____

E-mail address_____

Insured date of birth_____

Payment method ☐ Cash ☐ Check ☐ Credit card

EMERGENCY CONTACT

Name _____

Relation _____

Home phone _____

Work phone _____

Cell phone _____

WOMEN'S HEALTH

Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking birth control?	☐ Yes	☐ No
Do you experience painful periods?	☐ Yes	☐ No
Do you have irregular cycles?	☐ Yes	☐ No
Do you have breast implants?	☐ Yes	☐ No

HEALTH HABITS

	Yes	No
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you drink coffee, tea or soda?	☐	☐
Do you exercise regularly?	☐	☐

Do you wear:

☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office?_____ _____

Have you seen or heard about us in/on: ☐ Paper ☐ Sign ☐ YP

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits? _____

Doctor's name:_____

Approximate date of last visit:_____

Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No

Has any child in your family seen a Chiropractor? ☐ Yes ☐ No

CHIROPRACTIC PRINCIPLES

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

REASON FOR THS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall

☐ Home Injury ☐ Chronic Discomfort ☐ 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 ☐ comes and goes

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 (s) _____

Type of treatment _____

Results _____

MEDICATIONS I NOW TAKE...

☐ Cholesterol medication ☐ Blood pressure medicine

☐ Stimulants ☐ Blood thinners

☐ Tranquilizers ☐ Pain killers (including aspirin)

☐ Muscle relaxers ☐ _____

☐ Insulin ☐ _____

Vitamins & Supplements I now take:_____

_____

_____

_____

GOALS FOR MY 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 bodies. 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 my condition.**

REVIEW OF SYSTEMS

Constitutional ☐ I have not had nor do I currently have any of the symptoms or problems listed below.

☐ chills ☐ fatigue ☐ night sweats ☐ weight loss

☐ daytime drowsiness ☐ fever ☐ weight gain

Eyes/Vision: ☐ I have not had nor do I currently have any of the symptoms or problems listed below.

☐ blindness ☐ change in vision ☐ glaucoma ☐ tearing

☐ blurred vision ☐ double vision ☐ itching ☐ wear glasses/contacts

☐ cataracts ☐ eye pain ☐ light sensitivity

Ears/Nose/Throat ☐ I have not had nor do I currently have any of the symptoms or problems listed below.

☐ bleeding ☐ ear drainage ☐ hearing loss ☐ nosebleeds

☐ sore throat ☐ nasal congestion ☐ history of head injury ☐ postnasal drip

☐ hoarseness ☐ TMJ ☐ difficulty swallowing ☐ fainting

☐ ear pain ☐ discharge ☐ headaches ☐ frequent sore throats

☐ loss of smell ☐ snoring ☐ loss of sense of smell ☐ rhinorrhea (runny nose)

☐ tinnitus (ringing of the ears)

Respiration: ☐ I have not had nor do I currently have any of the symptoms or problems listed below.

☐ asthma ☐ coughing up blood ☐ sputum production

☐ cough ☐ shortness of breath ☐ wheezing

Cardiovascular:☐ I have not had nor do I currently have any of the symptoms or problems listed below.

☐ angina (chest pain or discomfort) ☐ high blood pressure ☐ chest pain

☐ low blood pressure ☐ swelling of legs ☐ claudication (leg pain/ache)

☐ heart murmur ☐ palpitation ☐ heart problems

☐ ulcers ☐ varicose veins

☐ orthopnea (dufficulty breathing lying down) ☐ shortness of breath with exertion or exercise

Office Use Only

REVIEW OF SYSTEMS CONT.

Office Use Only

Gastrointestinal: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ abdominal pain □ diarrhea □ indigestion □ abnormal stool
□ vomiting blood □ belching □ difficulty swallowing □ jaundice
□ heartburn □ nausea □ hemorrhoids □ rectal bleeding

Female: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ birth control □ cramps □ breast lumps/pain □ pregnancy
□ urination issues □ hormone therapy □ irregular menstruation

Male: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ urination issues □ prostate problems

Endocrine: □ .I have not had nor do I currently have any of the symptoms or problems listed below.

□ cold intolerance □ excessive hunger or thirst □ goiter □ unusual hair growth
□ diabetes □ voice changes □ hair loss □ excessive appetite

Skin: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ changes in nail texture □ hair loss □ itching □ skin lesion/ulcers
□ changes in skin color □ hives or rash □ hair growth □ varicose veins
□ history of skin disorders

Nervous System: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ dizziness □ limb weakness □ numbness □ slurred speech
□ tremor □ facial weakness □ loss of consiousness □ seizures
□ stress □ head ache □ loss of memory □ sleep disturbance
□ strokes □ unsteadiness of gait/loss of balance

Psychological: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ convulsions □ memory loss □ anxiety □ bi-polar disorder
□ depression □ confusion □ insomnia □ loss or change in appetite

Allergy: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ anaphalaxis □ itching □ sneezing □ food intolerance
□ nasal congestion □ rash

Hematological: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ anemia □ blood clotting □ bruising easily □ lymph node swelling
□ bleeding □ blood transfusion □ fatigue

Miscellaneous: □ I have not had nor do I currently have any of the symptoms or problems listed below.

□ mid back pain/stiffness □ neck pain/stiffness □ low back pain/stiffness
□ history of car accident □ any other accidents □ any falls □ any sports injuries

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 it's staff.

I understand that, under the 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 physicians 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 (Print):_____

Relationship to Patient:_____

Signature:_____ Date:_____

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.

_____ _____

Signature Date

_____ _____

Guardian or Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account?

☐ **Patient** ☐ **Spouse** ☐ **Parent** ☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Medicare** ☐ **Health Insurance**

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.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

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 maximal health.

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.

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.

Patient's Signature

_____Date_____

Witness_____