

ADULT MEMBER HEALTH RECORD

ABOUT YOU

| | |
|---|---------------------|
| NAME: | |
| ADDRESS: | |
| CITY: | STATE/ZIP CODE: |
| HOME PHONE: | CELL PHONE: |
| EMAIL ADDRESS: | |
| DATE OF BIRTH: | |
| AGE: | |
| SOCIAL SECURITY NUMBER: | HEIGHT & WEIGHT: |
| MARITAL STATUS: S M D W | NUMBER OF CHILDREN: |
| YOUR OCCUPATION: | |
| EMPLOYED BY: | |
| WORK PHONE: | SPOUSE'S NAME: |
| PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD | |

ABOUT YOUR INSURANCE

| | |
|-----------------------------|---------------|
| MAJOR MEDICAL INSURANCE CO: | |
| GROUP NUMBER: | |
| ID NUMBER: | |
| OTHER HEALTH INSURANCE CO: | GROUP NUMBER: |
| ID NUMBER: | |

HEALTH HABITS

| | |
|---|--------------------------------|
| DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, how long? |
| DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO | Occasional / Moderate / Excess |
| RATE YOUR STRESS LEVELS: | |
| Extreme Stress | Moderate Stress |
| Low Stress | |
| DO YOU EXERCISE AT LEAST 3-5 TIMES PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| ON A SCALE FROM 0-10, WHERE WOULD YOU PLACE YOURSELF? | |
| "I'm alive" | "I can live with this" |
| 0 1 2 | 3 4 5 6 |
| "I want to be the best I can be" | |
| 7 8 9 10 | |

REASON FOR THIS VISIT

| | |
|--|---------------|
| WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? | |
| HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? YES NO | |
| IF SO, WHEN? | |
| LIST YOUR MAIN COMPLAINTS IN ORDER OF IMPORTANCE TO YOU: | |
| 1. | FOR HOW LONG? |
| 2. | FOR HOW LONG? |
| 3. | FOR HOW LONG? |

REASON FOR THIS VISIT

| | |
|--|--|
| LIST OTHER DOCTORS SEEN FOR THESE CONDITIONS: | |
| DID YOU HAVE A SPECIFIC ACCIDENT, INJURY OR EVENT TO CAUSE THIS? | |
| HOW LONG HAS THIS BEEN GOING ON? | |
| HOW MANY TIMES HAS THIS HAPPENED IN THE PAST? | |
| HOW OFTEN DOES THIS HAPPEN? | |
| PLEASE RATE YOUR PAIN / SYMPTOMS? 0=NO PAIN 10= EXTREME | |
| 0 1 2 3 4 5 6 7 8 9 10 | |
| WHAT PERCENTAGE OF THE TIME ARE THE SYMPTOMS PRESENT? | |
| 100% - CONSTANT 75% 50% 25% | |
| ARE THE SYMPTOMS: | |
| Getting Worse Getting Better Staying the same | |
| WHAT MAKE S THIS PROBLEM WORSE? | |
| WHAT MAKES THIS PROBLEM BETTER? | |

GOALS FOR YOUR CARE

What things is this condition/problem keeping you from doing in your life? What have you had to stop doing or cut back on because of this problem?

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**

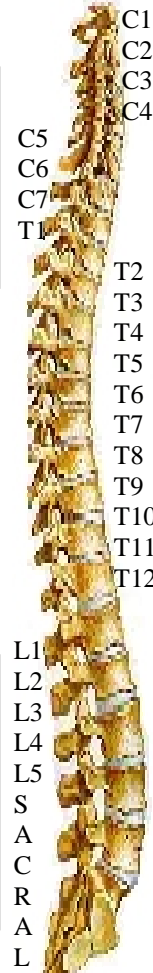
MEDICATIONS YOU TAKE

| | |
|--|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> VITAMINS & SUPPLEMENTS: | |

YOUR CONCERNS

INSTRUCTIONS: Please **circle** any other health conditions or concerns you are currently experiencing, even if you don't think it's related to your primary concerns.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions



C1 Headaches
Migraines
C2 Dizziness
C3 Sinus Problems
C4 Allergies
Fatigue
Head Colds
C5 Vision Problems
C6 Difficulty Concentrating
C7 Hearing Problems
T1

T2
T3
T4 Middle Back Pain
Congestion
T5 Difficulty Breathing
T6 Bronchitis
T7 Pneumonia
T8 Gallbladder Conditions
T9 Stomach Problems
T10 Ulcers
T11 Gastritis
T12 Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

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 the possibility of being accepted for care.

| | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> SEVERE OR FREQUENT HEADACHES | <input type="checkbox"/> THYROID PROBLEMS | <input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS | <input type="checkbox"/> NUMBNESS | FOR WOMEN ONLY: |
| <input type="checkbox"/> HEART SURGERY/PACEMAKER | <input type="checkbox"/> SINUS PROBLEMS | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> ALLERGIES | ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> LOWER BACK PROBLEMS | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> DIABETES | IF YES, WHEN IS YOUR DUE DATE? |
| <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> ULCERS/COLITIS | <input type="checkbox"/> SURGERIES: | ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> PAIN BETWEEN SHOULDERS | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> ASTHMA | ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> LOSS OF SLEEP | DO YOU: EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> FREQUENT NECK PAIN | <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> SHINGLES | <input type="checkbox"/> DIZZINESS | |

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.

| | |
|--|-------|
| SIGNATURE: | DATE: |
| | |
| GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE: | DATE: |
| | |
| WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT? | |
| <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> WORKERS COMP <input type="checkbox"/> AUTO INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> HEALTH INSURANCE | |

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 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.

| | |
|--------------------|-------|
| SIGNATURE: | DATE: |
| | |
| WITNESS SIGNATURE: | DATE: |
| | |

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:

ADDITIONAL NOTES: