ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	DATE:
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMERGENCY PHONE NUMBER:	AGE:
DATE OF BIRTH:	GENDER:
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER NAME:	
OCCUPATION:	
EMPLOYER CITY:	EMPLOYER STATE:
WORK HOURS PER WEEK:	DURING WORK I MOSTLY: ☐ SIT ☐ STAND ☐ WALK
WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?	

ABOUT YOUR SPOUSE/PARTNER

SPOUSE/PARTNER NAME:	
SPOUSE/PARTNER OCCUPATION:	
WORK HOURS PER WEEK:	EMPLOYER CITY/STATE:
EMPLOYER NAME:	

HEALTH HABITS

DO YOU SMOKE? ☐ YES ☐ NO If yes, how much per day________

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO If yes, how much per week________

DO YOU DRINK COFFEE, TEA, OR SODA If yes, how much per day________

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

LIST THE FIVE FOODS YOU EAT MOST OFTEN:

DO YOU GET RESTFUL SLEEP? ☐ YES ☐ NO ☐ SOMETIMES

Hours of sleep per night on average _________

CHIROPRACTIC EXPERIENCE

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:

DID YOU GET THE RESULTS YOU WANTED?

WERE THEY PERMANENT?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

WHAT IS YOUR OBJECTIVE IN CONSULTING THIS OFFICE?

WHAT IS YOUR MAIN SOURCE OF STRESS? (CHOOSE ONE)

☐ MENTAL/EMOTIONAL ☐ PHYSICAL ☐ CHEMICAL

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:

☐ GOTTEN WORSE ☐ STAYED CONSTANT ☐ COME AND GONE

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:

TYPE OF TREATMENT:

RESULTS:

GOALS FOR YOUR CARE

What are your expectations regarding your chiropractic care?

FOR DOCTOR'S USE ONLY—DO NOT MARK BELOW

□ Temporary symptom relief only □ Relief and Correction for Prevention of recurrence
□ Health Maintenance
□ Health Development & Growth with Chiropractic

FOR WOMEN ONLY

ARE YOU PREGNANT? ❑ YES ❑ NO
IF YES, WHEN IS YOUR DUE DATE?
ARE YOU NURSING? ❑ YES ❑ NO
ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
DO YOU: EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO HAVE IRREGULAR CYCLES? ❑ YES ❑ NO NOW EXPERIENCE MENOPAUSE? ❑ YES ❑ NO

MEDICATIONS YOU TAKE

❑ CHOLESTEROL MEDICATIONS	❑ BLOOD PRESSURE MEDICINE
❑ STIMULANTS	❑ BLOOD THINNERS
❑ ANTIDEPRESSANTS	❑ PAIN KILLERS (INCLUDING ASPIRIN)
❑ MUSCLE RELAXERS	❑ OTHER:
❑ INSULIN	❑ OTHER:
❑ VITAMINS & SUPPLEMENTS:	

YOUR CONCERNS

INSTRUCTIONS: *Please* ***CIRCLE THE HEALTH CONCERNS*** *or conditions you may be experiencing now or have in the past 6 months. 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
Difficulty Concentrating
Hearing Problems

C5 C6 C7 T1

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

T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

Middle Back Pain
Digestive Problems
Difficulty Breathing
Bronchitis
Pneumonia
Diabetes
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

L1 L2 L3 L4 L5 S A C R A L

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

OTHER:

____
____
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____
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____
____

LIFESTYLE SURVEY

1. If your health could be perfect for you, what would it look like?

2. What do you think you might have to do to create the level of health you described?

3. If we could help you create the level of health you just described, what would be so great about it? What would you be able to do that you can't do now? What would you stop doing that you hate doing?

4. What do you have available to you to measure your progress even after symptoms are gone?

5. Do you have a plan to elevate your level of health to where you want to be? Did you stay on it? What kind of results did you get? Have you ever been to a doctor who put you on a health development program? Were they permanent?

AUTHORIZATION FOR CARE & TERMS OF ACCEPTANCE

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. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

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.

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 the body's ability to adapt itself to its environment and keep you functioning at your best.

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 chiropractic adjusting to correct vertebral subluxation.

24 Hour Cancellation notice required on all appointments (adjustments excluded) to avoid a $50 missed appointment fee.

SIGNATURE:	DATE:
GUARDIAN SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

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.

PRINT NAME:	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

DO NOT WRITE BELOW—FOR DOCTOR’S USE ONLY

DOCTOR’S NOTES:

Stress Survey

Purpose: To determine if any health problems you may be having are due to stress.

Name ____ Age: ________ Phone: ___________________________

Address ____ City __________________ State ______ Zip _________

Email: ____

Occupation: ____ #Hrs/week working ______________________

On a scale of 0-10 (0 is no stress and 10 is overwhelmed) rate your stress level on an AVERAGE day.

0 1 2 3 4 5 6 7 8 9 10

Please check off any and all symptoms you may have experienced in the past 6 months, even if they do not seem related to chiropractic or the reason you came to this office.

- ☐ High Energy
- ☐ Few Symptoms
- ☐ Resistant to Infections
- ☐ Positive Mental Attitude
- ☐ Mentally Alert
- ☐ Excellent Health
- ☐ Active
- ☐ Vibrant

- ☐ Poor Attention
- ☐ Impulsive
- ☐ Easily Distracted
- ☐ Disorganized
- ☐ Depressed
- ☐ Lacking Motivation
- ☐ Poor Concentration
- ☐ Spaciness
- ☐ Constipation
- ☐ Low Pain Threshhold
- ☐ Difficulty Waking
- ☐ Worry
- ☐ Irritable
- ☐ Low Energy

- ☐ Migraines
- ☐ Headaches
- ☐ Seizures
- ☐ Sleepwalking
- ☐ Hot Flashes
- ☐ PMS
- ☐ Food Sensitivities
- ☐ Bedwetting
- ☐ Eating Disorders
- ☐ Bipolar Disorder
- ☐ Mood Swings
- ☐ Panic Attacks

- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Tight Muscles
- ☐ Teeth Grinding
- ☐ Anxiety
- ☐ Heart Palpitations
- ☐ Restless Sleep
- ☐ Poor Expression of Emotions
- ☐ Poor Immune System
- ☐ Racing Mind
- ☐ High Blood Pressure
- ☐ Accelerated Aging
- ☐ Irritable Bowel

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ ALS
- ☐ Epstein-Barr Syndrome

"Stress is associated with just about every chronic disease we know." ~ Jill Goldstein, Ph.D., Research Director, Brigham & Womens Hospital, Boston, Ma. 2010

"Stress accounts for nearly 80% of all symptom related doctor visits." ~ Johns Hopkins Research Study