

# ADULT HEALTH RECORD

## ABOUT YOU

NAME:		
ADDRESS:		
CITY:	STATE/ZIP:	
HOME PHONE:	CELL PHONE:	
EMAIL ADDRESS:		
DATE OF BIRTH:		AGE:
GENDER:		
MARITAL STATUS:	NUMBER OF CHILDREN:	
EMPLOYER NAME:		
OCCUPATION:		
EMPLOYER CITY:	STATE:	
EMPLOYER PHONE:		

## ABOUT YOUR SPOUSE

SPOUSE NAME:	
CELL PHONE:	
SPOUSE EMPLOYER:	
EMPLOYER CITY/STATE:	

## HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per day? _____
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per week? _____
DO YOU DRINK COFFEE, TEA OR SODA	If yes, how much per day? _____
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU WEAR: <input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> ARCH SUPPORTS	

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (V ALL THE APPLY): <input type="checkbox"/> SIGN <input type="checkbox"/> WEBSITE <input type="checkbox"/> EVENT <input type="checkbox"/> PHONE BOOK <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATED DATE OF LAST VISIT:
HAS ANY ADULT 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: <input type="checkbox"/> WELLNESS <input type="checkbox"/> JOB <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

## WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?
<input type="checkbox"/> YES <input type="checkbox"/> NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?
<input type="checkbox"/> YES <input type="checkbox"/> NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?
<input type="checkbox"/> YES <input type="checkbox"/> NO

## 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 my condition.*

## MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICATION
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS (INCLUDING ASPIRIN)
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER:
<input type="checkbox"/> INSULIN	<input type="checkbox"/> OTHER:
<input type="checkbox"/> VITAMINS & SUPPLEMENTS:	

## 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.

Sore Throat Stiff Neck Radiating Arm Pain Hand/Finger Numbness Asthma Allergies High Blood Pressure Heart Conditions	C5 C6 C7 T1		C1    Headaches C2    Migraines C3    Dizziness C4    Sinus Problems Allergies Fatigue Head Colds Vision Problems Difficulty Concentrating Hearing Problems  T2    Middle Back Pain T3    Congestion T4    Difficulty Breathing T5    Bronchitis T6    Pneumonia T7    Gallbladder Conditions T8    Stomach Problems T9    Ulcers T10   Gastritis T11   Kidney Problems T12
Constipation Colitis Diarrhea Gas Pain Irritable Bowel Bladder Problems Menstrual Problems Low Back Pain Pain or Numbness in legs Reproductive Problems	L1 L2 L3 L4 L5 S A C R A L		<b>OTHER:</b> _____ _____ _____ _____

## 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	<b>FOR WOMEN ONLY:</b>
<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	

## TERMS OF ACCEPTANCE

When a person seeks chiropractic care, it is essential that both the doctor and patient be working towards the same objectives. Chiropractic has only one goal that is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are located in and protected by the bones of the spine. Misalignments of the vertebrae (bones of the spine) which interfere with the function of these nerve pathways are called **vertebral subluxations**. Subluxations are caused by many of the things you do **every day** and keep your **whole** body from functioning properly. It is our absolute conviction that the **body is always better off without this interference**.

Consequently, the objective of this office is to provide chiropractic adjustments to correct subluxations thereby restoring normal nerve function. **With a proper nerve supply your whole body is better able to reach its full potential and to express more life.**

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.*

\_\_\_\_\_  
**Initials**

## AUTHORIZATION FOR CARE

I hereby authorize the Doctor to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor 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 if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

*I have read and fully understand that I am personally responsible to pay for all services rendered in this office.*

\_\_\_\_\_  
**Initials**

## 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, announcement 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 & direct my care and follow up with multiple healthcare providers who may be involved in that care directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessment 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.*

\_\_\_\_\_  
**Initials**

PATIENT NAME (PLEASE PRINT)	RELATIONSHIP TO PATIENT
SIGNATURE	DATE