

# PATIENT HEALTH RECORD

## ABOUT THE PATIENT

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip \_\_\_\_\_ Home phone \_\_\_\_\_  
 Birth date \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Age \_\_\_\_\_ Gender \_\_\_\_\_ Number of children \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work address \_\_\_\_\_  
 Work phone \_\_\_\_\_  
 Type of work \_\_\_\_\_  
 Marital Status \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Payment method  Cash  Check  Credit card

## ABOUT THE PARTNER

Name \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work phone \_\_\_\_\_  
 Type of work \_\_\_\_\_

## 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

## REASON FOR THIS 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 you 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 \_\_\_\_\_

## HEALTH HABITS

	No	Yes
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink coffee, tea or soda?	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear:		
<input type="checkbox"/> Heel lifts	<input type="checkbox"/> Sole lifts	<input type="checkbox"/> Inner soles

# AWARENESS OF THE 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

Please **circle** the health concern or concerns you may be experiencing now or have experienced in the past. Each are of concern relates to an area of the spine and nerve function.

## 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.**

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 - Dizziness  
C3 Sinus Problems - Allergies  
C4 Fatigue - Head Colds  
Vision Problems  
Difficulty Concentrating  
Hearing Problems

T2  
T3  
T4  
T5  
T6  
T7  
T8  
T9  
T10  
T11  
T12

Middle Back Pain  
Congestion  
Difficulty Breathing  
Bronchitis - Pneumonia  
Gallbladder Conditions  
Stomach Problems  
Ulcers - Gastritis  
Kidney Problems

## 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: \_\_\_\_\_

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

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has 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.

**For women:**

- 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

- Severe or frequent headaches  Heart surgery/pacemaker  Arthritis
- Sinus problems  Heart attack/stroke  Shingles
- Dizziness  Heart murmur  Kidney problems
- Loss of sleep  Congenital heart defect  Diabetes
- Pain between shoulders  Chemotherapy  Thyroid problems
- High/Low blood pressure  Difficulty breathing  Hepatitis
- Frequent neck pain  Surgeries \_\_\_\_\_
- Numbness in Arms/legs/hands  Alcohol/drug abuse
- Asthma  Rheumatic fever  Tuberculosis
- Lower back problems  HIV/AIDS  \_\_\_\_\_
- Digestive problems  Ulcers/Colitis  \_\_\_\_\_

# 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.

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 maximal 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.

Patient's Signature \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

# 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: \_\_\_\_\_

# Patient Case History (Clinic Use Only)

**Chief Concerns:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**History of Condition:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Associated Symptoms:** \_\_\_\_\_  
\_\_\_\_\_

**Aggravating Factors:** \_\_\_\_\_  
\_\_\_\_\_

**What has been done to help this condition?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prior Illness, Surgery, Accidents:** \_\_\_\_\_  
\_\_\_\_\_

**Family Health History:** \_\_\_\_\_  
\_\_\_\_\_

**Other:** \_\_\_\_\_  
\_\_\_\_\_