(For Office Use Only)
Name____________________
Date______________________
Case Number_______________

Patient Health Record

Welcome to our Chiropractic Office
Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific chiropractic care.

About The Patient

Name ____

Address______________________________________

City__________________State_____ Zip__________

Home Phone_____________ Cell__________________

Email____

D.O.B.__________Age____ Gender □ Male □ Female

Employer_____________________________________

Work Address_________________________________

Work Phone___________________________________

Type of Work_________________________________

Marital Status □ Married □ Single □ Divorced
□ Separated □ Widowed

Whom may we thank for referring you into our office?

____

Payment Method □ Cash □ Check □ Credit Card

____

____

About The Spouse or Parent

Name____

Employer_____________________________________

Work Phone___________________________________

Type of Work_________________________________

Reason For This Visit

Describe the purpose of this visit ______________________

____

Is the purpose of this appointment related to:

□ Job □ Sports □ Auto □ Fall

□ Chronic Discomfort □ Home Injury □ Other

Please Explain________________________________

If job related, have you made a report of the 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

Explain:______________________________________

Has this condition occurred before? □ Yes □ No

Explain:______________________________________

Have you seen other doctors for this condition?

□ Yes □ No

Doctor's Name_________________________________

Type of Treatment______________________________

Results_______________________________________

Health Insurance Info

Insurance Carrier______________________________ Ins. Phone #____________________________

Address____

Policy #_______________________________________ Group #________________________________

Relationship to Insured Self Spouse Child Other

If you are covered under another person's insurance…. Please complete______________________

Name of Insured_______________________________ M F Date of Birth____________________

Address of Insured____

Experience With Chiropractic

Have you ever been adjusted by a Chiropractor before? □ Yes □ No

Reason for those visits?____

Doctor's Name____

Approximate Date of Last Visit_______________________________________

Medications I Now Take

- □ Nerve Pills
- □ Pain Killers (including aspirin)
- □ Muscle Relaxers
- □ Blood Pressure
- □ Insulin
- □ Stimulants
- □ Blood Thinners
- □ Tranquilizers
- □ ___________
- □ ___________
- □ ___________

Health Habits

	No	Yes
Do You Smoke?	□	□ _____ packs/day
Do You Drink Alcohol?	□	□ _____ drinks/day
Do You Drink Coffee?	□	□ _____ cups/day
Do You Exercise Regularly	□ No	□ Moderately □ Daily
Do You Wear	□ Heel Lifts	□ Arch Supports

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.

- □ Severe or Frequent Headaches
- □ Sinus Problems
- □ Dizziness
- □ Loss of Sleep
- □ Pain between the Shoulders
- □ Frequent Neck Pain
- □ Numbness or Pain in Arm/Legs/Hands
- □ Lower Back Problems
- □ Ulcerative Colitis
- □ Heart Attack
- □ Congenital Heart Defect
- □ Heart Surgery/Pacemaker
- □ Heart Attack/Stroke
- □ Heart Murmur
- □ High/Low Blood Pressure
- □ Difficulty Breathing
- □ Asthma
- □ Arthritis
- □ Thyroid Problems
- □ Digestive Disorders
- □ HIV/Aids
- □ Stroke
- □ Shingles
- □ Kidney Problems
- □ Hepatitis
- □ Cancer
- □ Chemotherapy
- □ Anemia
- □ Rheumatic Fever
- □ Psychiatric Problems
- □ Alcohol/Drug Abuse
- □ Venerial Disease
- □ Tuberculosis
- □ Diabetes

For Women:

Are you pregnant? □ No □ Yes

Are you nursing? □ No □ Yes

Are you taking Birth Control? □ No □ Yes

Do you experience painful periods? □ No □ Yes

Do you have irregular cycles? □ No □ Yes

Do You Have Breast Implants? □ No □ Yes

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.

______________________________________ ______________________________________

Patient's Signature Date Guardian or Spouse's Signature Date

In An Emergency, Contact:

Name_________________________________

Relationship___________________________

Work Phone___________________________

Home Phone___________________________

Cell Phone____________________________

Informed Consent

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Disc Herniations: Disk herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes herniations in both the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This usually occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis in their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

Stroke: Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only: this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA. Vol. 37 No.2, June 1993) estimates that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to e in practice for hundreds of years before he/she would statistically be associated with a single patient stroke.

Other problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

Please feel free to ask us any questions you may have. When you have a full understanding of the above, please sign and date below.

____
Patient Name Printed

____ ______________
Patient Signature Date

____ ______________
Parent or Guardian Signature for a Minor Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such 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 used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's ability to correct vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being - NOT merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes an alteration of nerve function and interference to the transmission of mental impulses, resulting in a reduction of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if in 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 another health care provider.

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 body function and optimum health. Our only method is specific adjusting to correct vertebral subluxations.

I, ________________________________ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

____ __________________
(Signature) (Date)

HIPPA:

Protecting the privacy of your personal health information is very important to us.

The Office's privacy policy was available for me to read. I understand I may request a copy of this policy for my own records.

I, ________________________________ have read and fully understand the above statements.
(Print Name)

____ __________________
(Signature) (Date)

Parents, please complete:

Consent to evaluate and treat a minor child

I, ______________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____________________________________ ____________________
Signature Date