

Adult Member Health Record

PERSONAL INFORMATION

NAME: _____ (LEGAL FIRST) (Mi) (LEGAL Last)	
ADDRESS: _____	APT NO./SUITE _____
CITY: _____	STATE/ZIP CODE: _____
HOME PHONE: _____	CELL PHONE: _____
EMAIL ADDRESS: _____	
WE USE TEXT MESSAGING FOR APPOINTMENT REMINDERS. WHO IS YOUR CELL PHONE COMPANY? _____	
DATE OF BIRTH: _____	AGE: _____
SOCIAL SECURITY NUMBER: _____	(CIRCLE ONE) MALE FEMALE
MARITAL STATUS: M D/S S W	NUMBER OF CHILDREN: _____
EMPLOYER NAME: _____	
WORK PHONE: _____	TYPE OF WORK: (I.E. PROFESSIONAL, SECRETARIAL, TRADESPERSON, LABORER, HOMEMAKER, STUDENT, RETIRED)
EMERGENCY CONTACT: _____	PHONE: _____

INSURANCE INFORMATION

HEALTH INSURANCE COMPANY NAME (IF APPLICABLE) _____	
NAME OF INSURED: _____	
INSURED DOB _____	INSURED SSN# _____
HSA: YES <input type="checkbox"/> NO <input type="checkbox"/>	HRA: YES <input type="checkbox"/> NO <input type="checkbox"/>

HEALTH HABITS

DO YOU SMOKE? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL (AVG. 2 OR MORE/WK)? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA REGULARLY? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY? (AT LEAST 3 TIMES PER WEEK) _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

YOUR CONCERNS

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.

Thyroid problems Stiff Neck Radiating Arm Pain Hand/Finger Numbness Asthma Allergies High Blood Pressure Low Blood Pressure Headaches Dizziness	Jaw/TMJ problems Fatigue Vision Problems Hearing Problems Anxiety Depression Fevers/Night sweats Loss of Strength	Middle Back Pain Difficulty Breathing Gallbladder Conditions Diabetes Gastritis Hepatitis/Liver Problems Kidney Problems Urinary Tract Infections Constipation Colitis	Diarrhea Ulcers Irritable Bowel Menstrual Problems Low Back Pain Pain or Numbness in legs Prostate dysfunction Difficulty Urinating	DOES THE PAIN RADIATE? <input type="checkbox"/> RADIATES TO THE RIGHT BUTTOCK/THIGH <input type="checkbox"/> RADIATES TO THE LEFT BUTTOCK/THIGH <input type="checkbox"/> RADIATES TO THE RIGHT ARM/HAND <input type="checkbox"/> RADIATES TO THE LEFT ARM/HAND <input type="checkbox"/> OTHER: NOTES: _____ _____ _____
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CHIROPRACTIC EXPERIENCE

IS THERE SOMEONE WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? _____	
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING	
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DOCTOR'S NAME: _____	DATE OF LAST VISIT _____

FAMILY HEALTH HISTORY

CHECK THE FOLLOWING CONDITIONS UNDER THE APPROPRIATE RELATIVE THAT HAVE BEEN EXPERIENCED IN YOUR FAMILY EITHER PAST OR PRESENT.

RELATIVE	MOTHER	FATHER	SIBLING	GRANDPARENT
CANCER				
HIGH BLOOD PRESSURE				
HEART DISEASE				
STROKE				
BACK PAIN				

MAJOR SURGERIES

APPENDECTOMY / TONSILLECTOMY / GALL BLADDER / HERNIA / BACK SURGERY / BROKEN BONES
DATES: _____
OTHER: _____

MEDICATIONS

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> PAIN KILLERS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> MUSCLE RELAXORS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> HEART MEDICATIONS	<input type="checkbox"/> THYROID MEDICINE
<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<input type="checkbox"/> PROBIOTICS
<input type="checkbox"/> VITAMIN D	<input type="checkbox"/> CALCIUM/MAGNESIUM

FOR WOMEN ONLY

<input type="checkbox"/> PREGNANT WEEKS _____	<input type="checkbox"/> AMENORRHEA
<input type="checkbox"/> TRYING TO BE PREGNANT	<input type="checkbox"/> BIRTH CONTROL: TYPE _____
<input type="checkbox"/> MENSTRUAL CRAMPS	<input type="checkbox"/> PMS

***X-rays may be taken during the exam & x-rays can damage fetal development.**

Signature verifying patient is NOT pregnant: _____

PATIENT NAME: _____ **DATE:** _____

Please note that it's through your input that we are able to document medical necessity for your insurance. This is important because your insurance company may deny coverage for you if we cannot document medical necessity. Please help us by providing as much detail as possible.

1. Headaches: YES NO (If no, skip to # 2)

- Type of pain: Dull / Sharp / Achy / Shooting / Throbbing
- HOW OFTEN THEY OCCUR:** ___ DAILY ___ WEEKLY ___ MONTHLY # PER DAY ___ # PER MONTH ___
- How would you describe the amount of time that you have headaches? (circle one)
Constant (75-100%) Frequent (50-75%) Intermittent (25-50%) Occasional (0-25%)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room
Does the pain radiate? ___ Yes ___ No If so where? ___ To front ___ To back of head ___ Behind eyes ___ To side of head
What makes it better: _____
What makes it worse: _____

2. Neck Pain: YES NO (If no, skip to # 3)

- Type of pain: Dull / Sharp / Achy / Shooting / Throbbing
- How would you describe the amount of time that you have neck pain? (circle one)
Constant (75-100%) Frequent (50-75%) Intermittent (25-50%) Occasional (0-25%)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room
Does the pain radiate? YES NO If yes, where? Upper back ___ Right arm/hand ___ Left arm/hand ___
What makes it better: _____
What makes it worse: _____
Do you experience tingling or numbness in any of the following areas?
Head/Face _____ Lt arm/Lt Hand _____ Rt arm/Rt hand _____

3. Mid Back Pain: YES NO (If no, skip to # 4)

- Type of pain: Dull / Sharp / Achy / Shooting / Throbbing
- How would you describe the amount of time that you have mid back pain? (circle one)
Constant (75-100%) Frequent (50-75%) Intermittent (25-50%) Occasional (0-25%)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room
Does the pain radiate? YES NO If yes, where? Rib area ___ Chest area ___ Sternum ___ Shooting up/down
What makes it better: _____
What makes it worse: _____

4. Lower Back Pain: YES NO (If no, skip to # 5)

- Type of pain: Dull / Sharp / Achy / Shooting / Throbbing
- How would you describe the amount of time that you have low back pain? (circle one)
Constant (75-100%) Frequent (50-75%) Intermittent (25-50%) Occasional (0-25%)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room
Does the pain radiate? YES NO If yes, where? L/R Buttock ___ Lt Thigh ___ Rt Thigh ___ Lt foot ___ Rt foot
What makes it better: _____
What makes it worse: _____

Extremity Pain: YES NO If Yes, where?

Lt Shoulders ___ Rt Shoulder ___ Lt Elbow ___ Rt Elbow ___ Lt Wrist ___ Rt Wrist ___ Lt Hand ___ Rt Hand ___
Lt Hip ___ Rt Hip ___ Lt Knee ___ Rt Knee ___ Lt Ankle ___ Rt Ankle ___ Lt Foot ___ Rt Foot ___

- Type of pain: Dull / Sharp / Achy / Shooting / Throbbing
- How would you describe the amount of time that you have extremity pain? (circle one)
Constant (75-100%) Frequent (50-75%) Intermittent (25-50%) Occasional (0-25%)

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room
What makes it better: _____
What makes it worse: _____

IMPACT OF YOUR SYMPTOMS

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

AUTHORIZATION FOR CARE AND INFORMED CONSENT

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.

As with any health care problem there are certain complications that may arise during chiropractic adjustments and therapy. Soreness as in that experienced following exercise is most common. Dizziness, fractures/joint injury may occur but are extremely rare. Nerve damage or stroke is reported to occur once in one million to once in ten million adjustments. This is comparable to your chance of getting hit by lightning. Your chiropractor will make every reasonable effort to screen for complications of care; but if you have a condition that would not otherwise come to his/her attention, it is your responsibility to inform me. Other treatment options may include; self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalizations and surgery. If you choose one of these options listed you should be aware that there are risks and benefits of such options. The risks of remaining untreated: Remaining untreated may complicate treatment making it more difficult and less effective the longer it is postponed.

Do you have any questions regarding the above authorization statement and /or informed consent? ()NO ()YES, Please explain: _____

SIGN IF READ ABOVE _____ DATE _____ DOCTOR/CA INITIALS: _____

SIGNATURE OF PARENT OR GUARDIAN IF MINOR CHILD _____ PRINT NAME: _____

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.

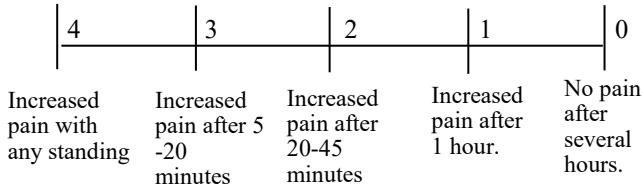
I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:
Would you like to authorize a family friend to have access to you PHI? (protected health information) YES NO	If yes please state Name of Family Member(s) _____ Signature of Patient: _____

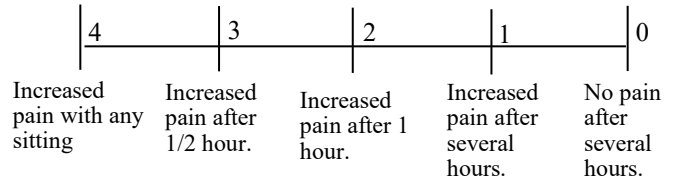
Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck or back problems** have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

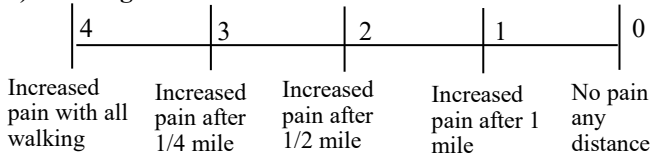
1.) Standing



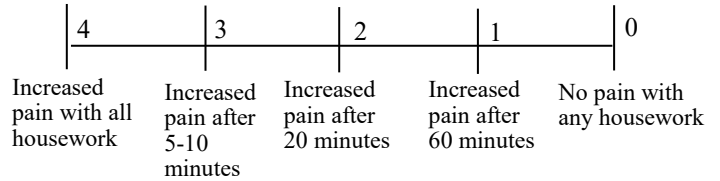
2.) Sitting



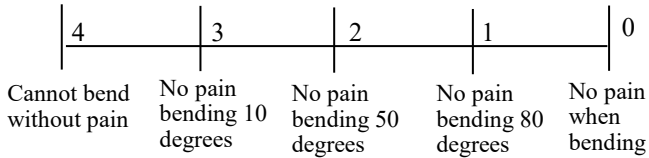
3.) Walking



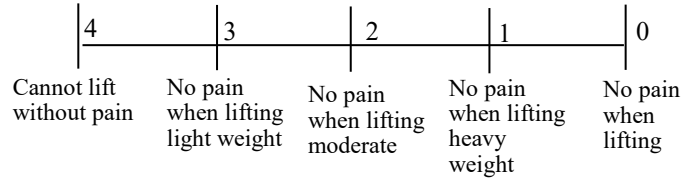
4.) Housework/ Work



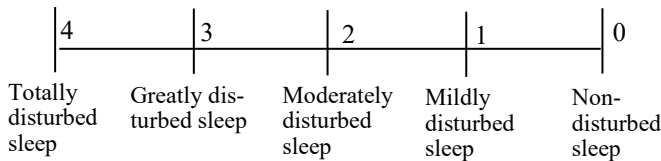
5.) Bending



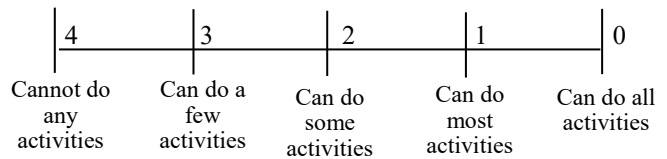
6.) Lifting



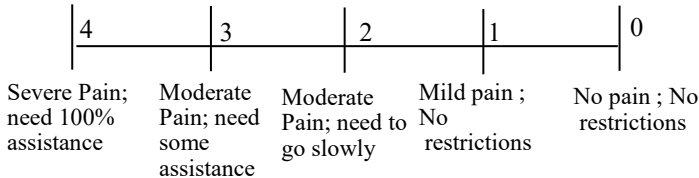
7.) Sleeping



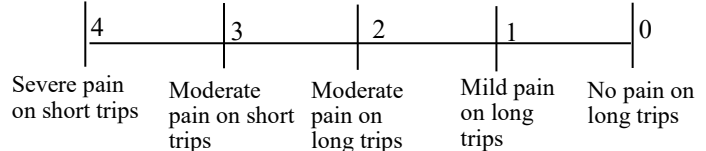
8.) Recreation



9.) Personal Care (washing, dressing, etc.)



10.) Travel (driving, etc.)



DOCTORS USE ONLY

INITIAL FREQUENCY 3 X A WEEK 2 X A WEEK ___ X A WEEK/MONTH FOR ___ WEEKS/MONTHS

CMT 1-2 AREAS 3-4 AREAS

PAIN INTENSITY GOAL:

SHORT-TERM: TO DECREASE THE BORG SCALE PAIN INTENSITY RATING TO A ___ OUT OF 10
 LONG-TERM: TO DECREASE THE BORG SCALE PAIN INTENSITY RATING TO A ___ OUT OF 10

FUNCTIONAL GOAL:

1. SHORT-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO _____
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)
 LONG-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO _____
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)
 2. SHORT-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO _____
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)
 LONG-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF _____ TO _____
(TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)