

# 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 SPOUSE

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

## EXPERIENCE WITH CHIROPRACTIC

Who may we thank for referring? \_\_\_\_\_  
Have you seen or heard about us in/on:  Paper  Sign  Website  
Have you been adjusted by a Chiropractor before?  Yes  No  
Reason for those visits? \_\_\_\_\_  
Doctor's name: \_\_\_\_\_  
Approximate date of last visit: \_\_\_\_\_  
Has anyone 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  Performance  
 Home Injury  Chronic Discomfort  Wellness

If other, please explain \_\_\_\_\_

If job related, have you made a report of your 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	<input type="checkbox"/> Arch supports

# 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 area 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.**

## MEDICATIONS I NOW TAKE...

- |   |   |
|---|---|
| <input type="checkbox"/> Cholesterol medication | <input type="checkbox"/> Blood pressure medicine          |
| <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"/> _____                            |
| <input type="checkbox"/> Insulin                | <input type="checkbox"/> _____                            |
- Vitamins & Supplements I now take: \_\_\_\_\_

## HEALTH CONDITIONS

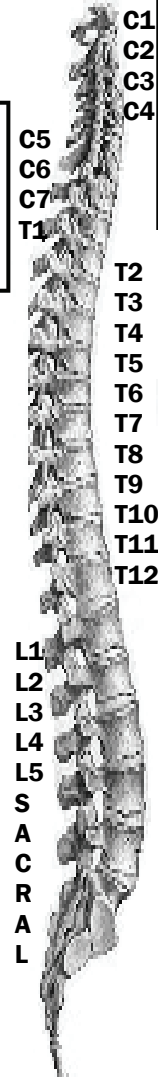
Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall evaluation, care plan and the possibility of being accepted for care.

- |   |  |
|---|--|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Heart surgery/pacemaker |
| <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Sinus problems               | <input type="checkbox"/> Heart attack/stroke     |
| <input type="checkbox"/> Shingles                     | <input type="checkbox"/> Dizziness               |
| <input type="checkbox"/> Ulcers / Colitis             | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Digestive problems      |
| <input type="checkbox"/> Loss of sleep                | <input type="checkbox"/> Congenital heart defect |
| <input type="checkbox"/> Pain between shoulders       | <input type="checkbox"/> Chemotherapy            |
| <input type="checkbox"/> High/Low High blood pressure | <input type="checkbox"/> Hepatitis               |
| <input type="checkbox"/> Difficulty breathing         | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Frequent neck pain           | <input type="checkbox"/> Surgeries _____         |
| <input type="checkbox"/> Numbness                     | <input type="checkbox"/> Pain in arms/legs/hands |
| <input type="checkbox"/> Frequent Colds               | <input type="checkbox"/> Lower back problems     |

### 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

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



**Headaches  
Migraines - Dizziness  
Sinus Problems  
Allergies - Fatigue  
Head Colds  
Vision Problems  
Difficulty Concentrating  
Hearing Problems**

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

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

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

# 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 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 (Print): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Case History (for doctors 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:** \_\_\_\_\_  
\_\_\_\_\_