ADULT HEALTH RECORD

ABOUT YOU

NAME:

ADDRESS:

CITY: | STATE AND ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

MAY WE LEAVE A MESSAGE FOR YOU AT HOME REGARDING YOUR CARE?
❑ YES ❑ NO, OR REGARDING YOUR APPOINTMENT? ❑ YES ❑ NO

DATE OF BIRTH: | GENDER:

MARITIAL STATUS: | NUMBER OF CHILDREN:

TYPE OF WORK YOU DO: | PHYSICAL STRESSORS AT WORK:

DO YOU HAVE A HSA OR FLEX SPENDING ACCOUNT THAT YOU WILL BE NEEDING RECEIPTS FOR? ❑ YES ❑ NO

ABOUT YOUR FAMILY

SPOUSE NAME (IF APPLICABLE):

CHILDREN'S NAME(S) AND AGE(S):

CHIROPRACTIC EXPERIENCE

HOW DID YOU HEAR ABOUT OUR OFFICE?

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

WHAT IS THE PURPOSE FOR THIS VISIT?
☐ WELLNESS* ☐ INJURY ☐ CHRONIC COMPLAINT ☐ OTHER
* If checked wellness, can skip to Health Choices at bottom of page.

PLEASE DESCRIBE:

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

HOW WOULD YOU DESCRIBE THE DISCOMFORT (CIRCLE ALL THAT APPLY)?
SHARP ACHEY TIGHT SORENESS SHOOTING
STIFFNESS TINGLING NUMBNESS OTHER

DOES THIS CONDITION INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

IS THE DISCOMFORT WORSE AT CERTAIN TIMES OF THE DAY?
☐ YES ☐ NO IF YES, EXPLAIN:

HOW WOULD YOU RATE THE SEVERITY OF YOU PAIN ON A SCALE OF 0-10?
0= NO DISCOMFORT 10= EXCRUTIATING PAIN

HOW OFTEN DO YOU EXPERIENCE THE DISCOMFORT?
☐ ALWAYS ☐ HOURLY ☐ DAILY ☐ OCCASIONALLY

LIST ANYTHING THAT AGGRAVATES YOUR CONDITION:

LIST ANYTHING THAT RELIEVES OR IMPROVES YOUR CONDITION:

HAS THIS CONDITION OCCURRED BEFORE?
❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?
❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

HEALTH CHOICES

ALCOHOL: DAILY WEEKLY OCCASIONALLY NEVER	DIET/LIGHT FOOD/DRINKS: DAILY WEEKLY OCCASIONALLY NEVER	CUPS OF WATER PER DAY: 0 1 2 3 4 5 6 7 8 9 10
TOBACCO: DAILY WEEKLY OCCASIONALLY NEVER	SOFT DRINKS: DAILY WEEKLY OCCASIONALLY NEVER	EXERCISE: DAILY WEEKLY OCCASIONALLY NEVER
CAFFEINE: DAILY WEEKLY OCCASIONALLY NEVER	PROCESSED, PACKAGED & RESTAURANT FOOD: DAILY WEEKLY OCCASIONALLY NEVER	VEGGIES & FRUITS: DAILY WEEKLY OCCASIONALLY NEVER

DC Wellness Center
9479 Garland Lane North
Maple Grove, MN 55311

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

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. 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:** Correct and relieve the cause of the problem as well as the symptom.
- ❑ **Wellness care:** Relieve symptoms, correct the cause and maintain the highest state of health possible.
- ❑ ***I want the Doctor to select the type of care appropriate for my condition.***

SUPPLEMENTS/MEDICATIONS

PLEASE LIST ANY VITAMINS/HERBS/HOMEOPATHIES YOU ARE TAKING:

_____

_____

PLEASE LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT PURPOSE:

_____

_____

PLEASE LIST ANY OVER THE COUNTER MEDICATIONS (ASPIRIN, IBUPROFEN, ZANTAC, ETC) THAT YOU CURRENTLY TAKE (REGULAR OR PERIODICALLY):

_____

_____

YOUR CONCERNS

INSTRUCTIONS: Circle present complaints. Mark 'P' for past complaints.

Runny Nose
Swollen Adenoids
Laryngitis/Strep/Sore Throat
Tonsillitis
Croup
Chronic Cough
Thyroid Issues
Poor Weight Regulation
Stiff Neck and Shoulders
Numbness Tingling
Hay Fever

C1
C2
C3
C4
C5
C6
C7

Headaches/Migraines
ADD/ADHD
Sensory/Spectrum Disorder
Insomnia
Reflux/GI Issues
Ear Infections/Aches
Vision Problems
Sinus Trouble/Allergies
Colic/Irritability
Anxiety
Balance/Coordination Issues
Acne/Eczema
Epilepsy/Seizure

T1
T2
T3
T4
T5
T6
T7

Asthma
Cough/Cold
Breathing Trouble
Heart Conditions
Chest Pain
Bronchitis
Pneumonia
Congestion
Chronic Colds/Flu
Reflux/GERD
Fever
Stomach Problems: Pain/ Indigestion/Ulcers
Liver Problems

Allergies
Immunity Issues: sickness
Hyperactivity
Kidney Troubles
Constipation/Gas Pains
Irritable Bowel Syndrome
Colitis
Abdominal Cramps
Diarrhea
Bladder Issues
Acne/Rash/Eczema
Fatigue

T8
T9
T10
T11
T12
L1
L2
L3

OTHER:

_____
_____
_____
_____
_____
_____
_____
_____

Constipation
Bedwetting/ accidents
Sciatic/Leg Pain
Weak Ankles/Arches
Difficult, Painful or Frequent Urination
Foot/Ankle/Knee Pain
Low Back Pain
Spinal Curvatures

L4
L5
S
A
C
R
U
M

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.*

❑ HIGH OR LOW BLOOD PRESSURE	❑ DIABETES	❑ CANCER: _____	❑ NUMBNESS	**FOR WOMEN ONLY:**
❑ HEART SURGERY/ PACEMAKER	❑ DIFFICULTY SLEEPING	❑ CHEMOTHERAPY OR RADIATION	❑ DIZZINESS	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ THYROID ISSUES	❑ HEPATITIS	❑ RHEUMATIC FEVER	❑ FATIGUE	IF YES, WHEN IS YOUR DUE DATE?
❑ DIGESTIVE PROBLEMS	❑ FIBROMYALGIA	❑ ULCERS/COLITIS	❑ SURGERIES: _____	ARE YOU NURSING? ❑ YES ❑ NO
❑ MUSCLE CRAMPS/SPASMS	❑ KIDNEY PROBLEMS	❑ TUBERCULOSIS	❑ ASTHMA	ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
❑ RESTLESS LEG SYNDROME	❑ AUTOIMMUNITY	❑ ARTHRITIS	❑ OTHER: _____	DO YOU:
❑ FIBROMYALGIA	❑ CHRONIC FATIGUE SYNDROME	❑ SHINGLES	❑ OTHER _____	EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO DO YOU HAVE IRREGULAR CYCLES? ❑ YES ❑ NO DO YOU HAVE BREAST IMPLANTS? ❑ YES ❑ NO

FAMILY HISTORY REVIEW

Circle those involving immediate family and add identification: M=Mother, F=Father, S=Sibling, G=Grandparent

Cancer, Type_____ M / F / S / G	Depression M / F / S / G	Diabetes M / F / S / G	Back Problems M / F / S / G
Heart Disease M / F / S / G	Liver Disease M / F / S / G	High Blood Pressure M / F / S / G	High Cholesterol M / F / S / G
Lung Problems M / F / S / G	Scoliosis M / F / S / G	Neck Problems M / F / S / G	Osteoporosis M / F / S / G
Seizures M / F / S / G	Osteoarthritis M / F / S / G	Rheumatoid Arthritis M / F / S / G	Other _____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine and any other care as he or she finds necessary. Should we need to refer for further care, we will guide you. 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. I 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.

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.*

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

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.

SIGNATURE:	RELATIONSHIP TO PATIENT: