812 N. Main St.
Greer, SC 29650
864.469.7979

Date:____/____/_____

# Community Chiropractic Center Health History

Welcome to our office! Thank you for trusting us with your healthcare needs. Our office is focused on providing your family with the highest quality and most professional healthcare possible. Please complete the following health history information in order for us to properly assess your symptoms, function, health care challenges and health care goals. We look forward to a healthy relationship, working together to help you and your family reach your health and wellness goals.

| | | | | |
|---|---|---|---|---|
| **Last Name** | | **First Name** | | **Middle I.** |
| **Date of Birth** ___/___/_____ | **Age** | **Male/Female** | **Social Security Number** | |
| **Address** | | **City** | **State** | **Zip** |
| **Home Phone** ( ) | **Cell Phone** ( ) | **Cell Phone Provider** | **Email** | |
| **Occupation** | | **Employer's Name** | | |
| **Emergency Contact** | | **Phone Number** | | |
| **Marital Status** Single Married Divorced Widowed | | **Spouse's Name (or parent)** | **Number of Children** | |
| **Who may we thank for referring you?** | | | | |

# LIST YOUR HEALTH CONCERNS BELOW

| Health Concerns: List according to severity | Rate of Severity 1 = mild 10 = unbearable | When did this episode start? | If you had the condition before, when? | Did it begin with an injury? | Are symptoms constant or intermittent? |
|---|---|---|---|---|---|
| **1.**_____ | _____ | _____ | _____ | **Y/N** | _____ |
| **2.**_____ | _____ | _____ | _____ | **Y/N** | _____ |
| **3.**_____ | _____ | _____ | _____ | **Y/N** | _____ |
| **4.**_____ | _____ | _____ | _____ | **Y/N** | _____ |
| **5.**_____ | _____ | _____ | _____ | **Y/N** | _____ |

**HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? Y/N**

**CHIROPRACTOR? Y/N MEDICAL DOCTOR? Y/N OTHER? Y/N**

**WHO AND WHEN?**_____

## CIRCLE ALL CURRENT PROBLEMS YOU HAVE

| | | | | |
|---|---|---|---|---|
| *HEADACHES* | *ASTHMA* | *CHEST PAIN* | *SCIATICA* | *DISC PROBLEM* |
| *ANXIETY* | *IRRITABILITY* | *LIVER DISEASE* | *LOW BACK PAIN* | *GASTRIC REFLUX* |
| *DIZZINESS* | *FREQUENT COLDS* | *THROAT ISSUES* | *HIP PAIN* | *DIFFICULTY SLEEPING* |
| *EAR INFECTIONS* | *MID BACK PAIN* | *THYROID PROBLEMS* | *LEG PAIN* | *SHORT OF BREATH* |
| *VERTIGO* | *SHOULDER PAIN* | *HEART DISORDERS* | *KNEE PAIN* | *ARM PAIN* |
| *NAUSEA* | *ULCERS* | *DIABETES* | *LUPUS* | *MENSTRUAL PAIN* |
| *TMJ* | *DIGESTIVE ISSUES* | *HEARTBURN* | *CHRONIC FATIGUE* | *ARM NUMBNESS* |
| *NECK PAIN* | *DIARRHEA* | *IRRITABLE BOWEL* | *FIBROMYALGIA* | *LEG NUMBNESS* |
| *MIGRAINES* | *HYPERTENSION* | *BLADDER PROBLEMS* | *DEPRESSION* | *INFERTILITY* |
| *CHRONIC SINUS* | *CONSTIPATION* | *KIDNEY PROBLEMS* | *ADD/ADHD* | *PREGNANCY ISSUES* |
| *CARPAL TUNNEL* | *COLIC* | *WRIST PAIN* | *ALLERGIES* | *OTHER*_____ |
| *ARTHRITIS* | *EPILEPSY* | *RINGING IN EAR* | *NERVOUSNESS* | _____ |

## CIRCLE ANY CONDITION THAT YOU HAVE NOW OR HAVE HAD

**STROKE HEART DISEASE CANCER SPINAL SURGERY SEIZURES SPINAL FRACTURES SCOLIOSIS**

**LIST ALL SURGICAL OPERATIONS AND YEARS**_____

_____

**LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:**

_____

_____

**WHEN WAS YOUR LAST AUTO ACCIDENT**_____

**HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO**

**IF YOU HAVE, DR. & DATE**_____

**HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? Y / N FRACTURED A BONE? Y / N**

**IF YES, PLEASE DESCRIBE**_____

**OTHER TRAUMA:** _____

**HOW WOULD YOU RATE YOUR HEALTH? Excellent Good Average Fair Poor**

**WHAT ARE YOU CURRELTY DOING FOR YOUR HEALTH?** _____

_____

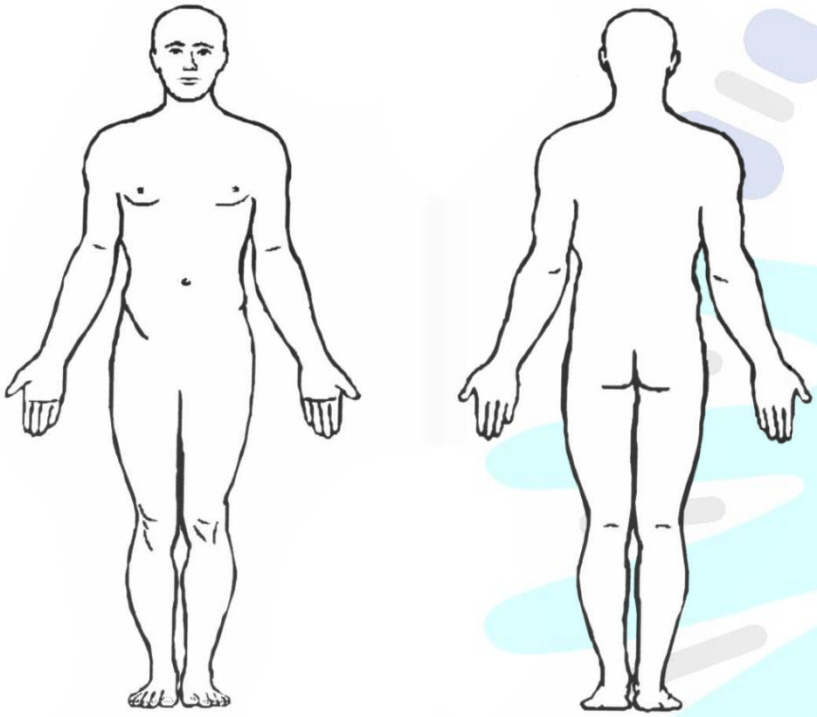
**WHAT DAILY ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS?** _____

_____

_____

**PLEASE MARK** the areas on the diagram with the following letters to describe your symptoms

**R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling**



**What relieves your symptoms?**

_____

_____

**What makes them feel worse?**

_____

_____

**Has this ever happened before?____**

**When? _____**

## SOCIAL HISTORY

1. **SMOKING:** ☐ **CIGARS** ☐ **PIPE** ☐ **CIGARETTES**
   **HOW OFTEN?** ☐ **DAILY** ☐ **WEEKENDS** ☐ **OCCASIONALLY** ☐ **NEVER**
2. **EXERCISE / HOW OFTEN**
   ☐ **DAILY** ☐ **WEEKENDS** ☐ **OCCASIONALLY** ☐ **NEVER**

***IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW**

## WRITTEN CONSENT FOR A CHILD

**NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD** _____

**I AUTHORIZE DR. JOEL COX AND ANY AND ALL COMMUNITY CHIROPRACTIC CENTER STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.**

**AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY COMMUNITY CHIROPRACTIC CENTER.**

_____ _____

**DATE** **GUARDIAN SIGNATURE**

_____ _____

**WITNESS SIGNATURE** **GUARDIAN'S RELATIONSHIP TO MINOR / CHILD**

# FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

DATE PLEASE PRINT YOUR NAME HERE

| CONDITION | SPOUSE | DAUGHTER | SON | MOTHER | FATHER |
|---|---|---|---|---|---|
| ARM PAIN | | | | | |
| ARTHRITIS | | | | | |
| ASTHMA | | | | | |
| ADD/ADHD | | | | | |
| ALLERGIES | | | | | |
| BACK TROUBLE | | | | | |
| BED WETTING | | | | | |
| CANCER | | | | | |
| CARPAL TUNNEL | | | | | |
| DECEASED | | | | | |
| DIABETES | | | | | |
| DIGESTIVE PROBLEMS | | | | | |
| DISC PROBLEMS | | | | | |
| EAR INFECTIONS | | | | | |
| FIBROMYALGIA | | | | | |
| HEADACHES | | | | | |
| HEARTBURN | | | | | |
| HIGH BLOOD PRESSURE | | | | | |
| HIP PAIN | | | | | |
| LEG PAIN | | | | | |
| MENSTRUAL DISORDER | | | | | |
| MIGRAINES | | | | | |
| NECK PAIN | | | | | |
| SCOLIOSIS | | | | | |
| SHOULDER PAIN | | | | | |
| SINUS TROUBLE | | | | | |
| TMJ | | | | | |

# INSURANCE INFORMATION

Even if you are here through a non-referral source such as an external workshop, we are happy to verify your insurance coverage. We will NEVER bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.

**Name of Primary Insurance Carrier:** _____

**Name of Insured:** _____ **Insured Date of Birth:** _____

**Insured Social Security Number:** _____

**Name of Secondary Insurance Carrier:** _____

# RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Joel Cox, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

**SIGNED**_____ **DATE**_____

# TERMS OF ACCEPTANCE/ CONSENT TO TREATMENT

The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. Misalignments of the spinal bones which interfere with the nervous system are called SUBLUXATIONS. Subluxations are a misalignment of one or more of the 24 vertebra which come from many causes and prevent various organs, glands, tissues and muscles from functioning properly.

OUR ONLY PRACTICE OBJECTIVE is to find and remove vertebral subluxations. Our only method is specific adjusting to correct neurological subluxations.

Chiropractic does not treat disease or symptoms. The doctor of chiropractic's only goal is to allow the body to function properly and his only means is the correction of the vertebral subluxation.

Please understand that chiropractic is NOT a substitute for medical treatments of any kind. Also, No statement of the chiropractor is intended as medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

When you take a drug or medication there is a risk of dangerous side effects. When any medical test or procedure is performed certain risk is involved. When you walk down stairs, drive a car, or play sports, there is always risk. On that note, chiropractic adjustments, which are always extremely safe and effective (a typical chiropractors malpractice insurance costs less than his car insurance), pose a very tiny degree of risk in certain situations. The most common side effects seen in a small percentage of people are post adjustment muscle soreness. This is comparative to post exercise soreness. This typically subsides quickly. If you do experience any post adjustment sensations please tell the doctor on your next visit. If you have any questions concerning the safety of chiropractic in certain situations, please explain this to the doctor. The doctor will give the utmost to care for you in the safest and most effective manner, just as he would his own family.

I have read the above, all questions regarding the doctor's objectives have been answered to my satisfaction and I understand it fully and undertake chiropractic care on this basis.

**X-RAY NOTE:**

INIT_____ I hereby give my consent to and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am NOT pregnant.

**SIGNED**_____ **DATE**_____

# HIPAA - Health Insurance Portability & Accountability Act

Community Chiropractic Center
812 N. Main St.
Greer, SC 29651
(864) 469-7979

The following is an explanation of our Privacy Policies for this office.

- Our office does NOT distribute or make available to any outside source your private personal health information.
- Your information is secure and is used only in submitting claims to third party carriers for payment of services.
- I give COMMUNITY CHIROPRACTIC CENTER permission to adjust me in a semi-closed room setting where other patients and office staff may able to overhear some of my PHI during the course of care. This semi-closed room environment is used for ongoing care, and is not the environment used for taking patient histories, performing examinations, or presenting report of findings, as these procedures are completed in a private, confidential setting.
- I give COMMUNITY CHIROPRACTIC CENTER our permission to use my name on the welcome board, referral board, birthday board, prize winning notices, and community information (i.e. newspaper clippings).
- I give COMMUNITY CHIROPRACTIC CENTER permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If COMMUNITY CHIROPRACTIC CENTER contacts me by phone, I give them permission to leave a message on my voice mail or answering machine.
- A family member can be present when hearing the results of your exam and tests.

A more detailed explanation of our policies is available for you to read and take a copy with you. Please ask the front desk for it.

By signing, I have read, understand and agree to the privacy policies for this office. I can take a copy for my records. I understand that if I choose not to participate that I can and will notify the Community Chiropractic Center staff of my concerns in writing.

**SIGNED**_____ **DATE**_____

**PRINTED**_____