CONTINUUM CHIROPRACTIC ADULT HEALTH HISTORY FORM

Today's Date_____

PERSONAL DATA

Legal Name _____Preferred Name_____

Age _____ Date of Birth _____ Height _____ Weight _____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____ SS#_____

E-mail address_____

Occupation _____ Employer _____

Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner _____

Names and Ages of Children_____

How did you hear about our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Continuum Chiropractic can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleeping:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N			

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____Why did you stop care?_____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Dentist ❑ Physical or Occupational Therapist

Reason:_____

_____

FOR WOMEN

Are you pregnant? Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.

Signature: _____Date:_____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife_____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

Is this your first pregnancy? Y N Number of other pregnancies: _____

Have you had any complications with this, or any other, pregnancy? Y N

Details:_____

_____

CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.

Please list the major traumas that you remember from your childhood up to the present. _____

_____

_____

Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

_____

Have you ever fractured or severely injured any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

_____

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: _____

Do you have allergies or sensitivities to food or other substances? ❑ Y ❑ N If yes, please list:

_____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

❑ Recreational drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

QUALITY OF LIFE (presently)

How do you grade your physical health? ❑ Good ❑ Fair ❑ Poor

How do you grade your emotional/mental health? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall "quality of life"? ❑ Good ❑ Fair ❑ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

In what position do you sleep at night? ❑ Back ❑ Stomach ❑ Side

How many hours of sleep do you get per night? _____ Quality? ❑ Good ❑ Fair ❑Poor

YOUR HEALTH HISTORY

Indicate C for current and P for past

____ Weight changes
____ Frequent infections
____ Respiratory disease
____ Sinus problems
____ Heart Disease
____ Joint pain
____ Allergies
____ Asthma
____ Numbness/Tingling
____ Cold hands/feet
____ Neck pain
____ Back pain
____ Arm/hand pain
____ Leg/foot pain
____ Memory issues
____ Thyroid disorder
____ Difficulty sleeping
____ Difficulty breathing
____ High cholesterol
____ Stroke
____ Nervous disorder
____ Digestive problems
____ Cancer
____ Menstrual problems/ pain
____ HIV or AIDS
____ High blood pressure
____ Low blood pressure
____ Headaches
____ Fatigue
____ Stress difficulty
____ Diabetes
____ Arthritis
____ Jaw/TMJ issues
____ Bowel/bladder habit changes
____ Concussion /Head injury
____ Neurological issue

Details:_____

_____

_____

FAMILY HEALTH HISTORY

Has any member of your family (parents, grandparents, or siblings) ever had any of the following conditions?

❑ Cancer ❑ Heart disease ❑ Stroke ❑ Diabetes

❑ Progressive neurological disease ❑ High blood pressure ❑ Other

Details:_____

_____

_____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Relief and Prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels
- ❒ OTHER_____

Important: Is there anything else that you would like our doctors to know? _____

_____

_____

_____

Describe aspects of your health that you feel are positive:

_____

_____

_____

_____

_____

INFORMATION ABOUT FINANCES

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

INSURANCE INFORMATION

Insurance coverage varies greatly. We do not look up or file insurance in this office, but will gladly print any necessary information if you choose to file on your own.

PLEASE READ AND SIGN

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Hayes Modlin and Dr. Thad Modlin permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____Date: _____

Signature:_____

Signature of Parent (for minor):_____ Date: _____

Thank you for choosing Continuum Chiropractic.
We look forward to helping you.

Continuum Chiropractic Informed Consent

Chiropractic care consists of the detection, analysis, and correction of vertebral subluxations. A chiropractic adjustment is designed to reduce and correct subluxations and not to cure or prevent any other disease or condition. The adjustment may be performed with the doctor's hand or with a mechanical instrument. This office does not diagnose or treat disease; we analyze the spine for vertebral subluxations. If during the course of a chiropractic spinal evaluation we encounter non-chiropractic or unusual findings then 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.

I hereby request and consent to the performance of chiropractic procedures as deemed necessary by Dr. Thad Modlin or Dr. Hayes Modlin or any other Doctor of Chiropractic employed by Continuum Chiropractic or serving as back-up doctor to either doctor now or in the future. Chiropractic procedures may include, but are not limited to, spinal adjustments, diagnostic x-rays, physical examination procedures, various modes of physiotherapy, and other supportive therapies.

I understand that chiropractic care, like all forms of health care, comes with a certain level of risk. In rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and fracture. I understand that Drs. Thad and Hayes will make every reasonable effort during the examination to screen for contraindications to care; however, I understand that it is my responsibility to inform him of all pre-existing medical conditions.

I have had an opportunity to discuss with Dr. Thad and/or Dr. Hayes the nature and purpose of chiropractic adjustments and procedures. I do not expect either doctor to be able to anticipate and explain all risks and potential complications. I wish to rely on them to exercise judgement during the course of my care and to act in my best interest based on the facts known at the time of treatment. I understand that results are not guaranteed.

I understand that there may be other treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered over the counter analgesics and rest, medical care with prescription drugs, physical therapy, steroid injections, bracing, and surgery. I also understand that remaining untreated may allow the formation of adhesions and a reduction in mobility which may exacerbate my current condition.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the terms as outlined above for the duration of my care.

_____
Printed name of Patient

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Doctor of Chiropractic Date

Continuum Chiropractic
Dr. Thaddeus & Dr. Hayes Modlin
27 S. Pleasantburg Dr Ste 60; Greenville, SC 29607

PRIVACY NOTICE ACKNOWLEDGEMENT

We at Continuum Chiropractic are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have reviewed a copy Continuum Chiropractic's *Notice of Privacy Practices for Protected Health Information.* I have been informed that a copy is available for further review upon my request.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Continuum Representative

_____

Personal Representative Printed

_____ _____

Personal Representative Signature Continuum Representative

_____

Description of personal representative's authority to act for the patient/practice member (i.e. relationship).

Continuum Chiropractic
Drs. Thad and Hayes Modlin
27 S. Pleasantburg Dr Ste 60
Greenville, SC 29607