ADULT PRACTICE MEMBER FORM

AUTHORITY CHIROPRACTIC

OFFICE USE ONLY

C	ID#
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T	Y/N
ABR	

PERSONAL INFORMATION

Full Name : Gender: ◯Male ◯Female

Address :

Date of Birth : / / Last 4 SSN: Marital Status: ◯Single ◯Married ◯Widowed ◯Divorced

Email : Cell Phone:

Occupation: Employer:

Spouse's Name: Number of Children:

Names & Ages of Children:

Who may we thank for referring you?

CURRENT HEALTH

What major health concerns bring you into our office?

When did the condition(s) first begin?

Have you received care for this problem before? ◯Yes ◯No - If yes, when?

If Yes: ◯Chiropractor ◯Medical Doctor ◯Other:

If Yes: Who? Results?

How did the problem(s) start? ◯Suddenly ◯Gradually ◯Post-Injury

This condition is: ◯Getting Worse ◯Improving ◯Intermittent ◯Constant ◯Unsure

What makes the problem better?

What makes it worse?

Past	Current	
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Jaw/TMJ Pain
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Arm Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Lower Back Pain
☐	☐	Hip/Leg Pain
☐	☐	Knee Pain
☐	☐	Foot Pain
☐	☐	Tight/Sore Muscles
☐	☐	Ear Infections
☐	☐	Hearing Loss
☐	☐	Ringing in the Ears

Past	Current	
☐	☐	Dizziness
☐	☐	Loss of Balance
☐	☐	Allergies
☐	☐	Sinus Issues
☐	☐	Frequent Colds
☐	☐	Asthma
☐	☐	Stress
☐	☐	Anxiety
☐	☐	Depression
☐	☐	ADD/ADHD
☐	☐	Double/Blurry Vision
☐	☐	Thyroid Issues
☐	☐	Loss of Energy
☐	☐	Heart Problems
☐	☐	Nausea
☐	☐	Digestive Issues

Past	Current	
☐	☐	GERD/Gastric Reflux
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Bed Wetting
☐	☐	Bladder Problems
☐	☐	Pregnant
☐	☐	Infertility
☐	☐	Menstrual Problems
☐	☐	Prostate Problems
☐	☐	Sexual Dysfunction
☐	☐	Diabetes
☐	☐	Stroke
☐	☐	Arthritis
☐	☐	Fibromyalgia
☐	☐	Chest Pain

Past	Current	
☐	☐	Difficulty Breathing
☐	☐	Tremors
☐	☐	Seizures
☐	☐	Cancer
☐	☐	Sleep Problems
☐	☐	Sports Injury
☐	☐	High Blood Pressure
☐	☐	Numb/Tingling in Arms
☐	☐	Numb/Tingling in Legs/Feet
☐	☐	Skin Problems
☐	☐	Sciatica
☐	☐	Scoliosis
☐	☐	Poor Posture
☐	☐	Spinal Surgery

Other:

List all surgical operations & years:

List all over the counter & prescription medications you are on, & the reason for each: (May use back of this page)

Other trauma:

List any other injuries to your spine, minor or major, that the doctor should know about:

Have you ever been in an auto accident? List all:

Do you have an open auto accident claim? ◯Yes ◯No

Have you ever been knocked unconscious? ◯Yes ◯No Fractured a bone? ◯Yes ◯No

If yes to either of the above, please describe:

Are you military or first responder? (Active or Retired)

Did you receive the COVID-19 injection? ◯Yes ◯No

SOCIAL HISTORY

Smoking: How often? ◯Daily ◯Weekends ◯Occasionally ◯Never

Alcohol: How often? ◯Daily ◯Weekends ◯Occasionally ◯Never

Exercise: How often? ◯Daily ◯Weekends ◯Occasionally ◯Never

Have you consumed any caffeine or caffeine products within the past 48 hours? ◯Yes ◯No

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

How would you rate your pain right now?

What is your typical or AVERAGE pain?

What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

What percentage of your awake hours is your pain at its best? %

What is your pain level at its WORST (How close to 10 does your pain get at its worst?)

What percentage of your awake hours is your pain at its worst? %

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Carrying Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climbing Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Household Chores	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Lifting Children	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Dressing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard Work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other:		○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other:		○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

How has your health affected your life in a negative way?

If your body was functioning and adapting better, what are 2 things you would be able to do?

FAMILY HEALTH HISTORY

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet 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 rarely, fractures.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is recommended, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a plan of care prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Authority Chiropractic. 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 practice member. 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.

PRINT NAME:

SIGNATURE: **DATE:**

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 Authority Chiropractic 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 Authority Chiropractic.

GUARDIAN SIGNATURE: **DATE:**

RELATIONSHIP TO MINOR/CHILD:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

SIGNATURE: **DATE:**

I authorize Authority Chiropractic to discuss my medical records with the following individuals:

X-Ray Authorization

X-rays are utilized in this office to analyze structural changes of the spine. Authority Chiropractic does not diagnose or treat medical conditions; however if any abnormalities outside the realm of chiropractic are found, we will bring it to your attention so that you can seek proper medical advice. Digital X-rays may be copied onto a CD if requested. Please allow up to 72 hours for copies to be made. Authority Chiropractic reserves the right to charge a $10 fee for copying these films.

PRINT NAME: **DATE OF BIRTH:**

SIGNATURE: **DATE:**

<u>FEMALES ONLY:</u> To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Authority Chiropractic.

SIGNATURE: **DATE:**