PATIENT HEALTH RECORD

Today's Date:_____

Name_____

Address_____

City_____State_____Zip _____

Date of Birth_____Age_____Gender_____

Social Security #:_____

Home phone _____Cell _____

Primary Physician_____Phone:_____

E-mail address:_____

Employer_____

Work phone _____

Type of work _____

Marital Status:_____ Spouse's Name:_____

Spouse's Employer:_____

Spouse's Work Number:_____

Emergency Contact:_____

Relationship:_____Home #:_____

Cell #:_____Work #:_____

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall
☐ Home Injury ☐ Chronic Discomfort ☐ Other

Please explain _____

If job related, have you made a report of this 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 _____

Who referred you to this office?_____

Have you seen or heard about us in/on: ☐ Sign ☐ Yellow Pages

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits? _____

Doctor's name:_____

Approximate date of last visit:_____

Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No

Has any child in your family seen a Chiropractor? ☐ Yes ☐ No

	No	Yes
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you drink coffee, tea or soda?	☐	☐
Do you exercise regularly?	☐	☐

Do you wear:

☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

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

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? _____ ☐ Yes ☐ No

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 treatment 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 symptoms

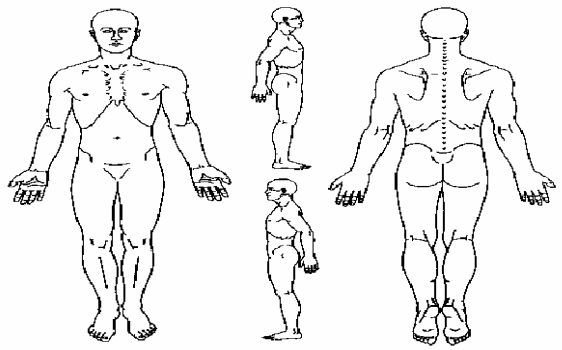
☐ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

☐ I want the Doctor to select the type of care appropriate for my condition.

Please indicate which medications you currently take:

☐ Cholesterol medicine ☐ Blood pressure medicine
☐ Stimulants ☐ Blood thinners
☐ Tranquilizers ☐ Pain killers (including aspirin)
☐ Muscle relaxers ☐ _____
☐ Insulin ☐ _____
Vitamins & Supplements I now take:_____
_____
_____

PLEASE MARK THE AREAS OF CONCERN



☐ **Throbbing** ☐ **Sharp** ☐ **Dull** ☐ **Numbness** ☐ **Aching** ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ **Cramps** ☐ **Stiffness** ☐ **Swelling**

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 diagnosis, care plan and the possibility of being accepted for care.

☐ Severe or frequent headaches
☐ Sinus problems
☐ Dizziness
☐ Loss of sleep
☐ Pain between shoulders
☐ Frequent neck pain
☐ Numbness in Arms/legs/hands
☐ Pain in Arms/legs/hands
☐ Lower back problems
☐ Digestive problems
☐ Heart surgery/ pacemaker
☐ Heart attack/stroke
☐ Heart murmur
☐ Congenital heart defect
☐ High/Low blood pressure
☐ Difficulty breathing
☐ Asthma
☐ Tuberculosis
☐ Alcohol/drug abuse
☐ Venereal disease
☐ HIV/AIDS
☐ Ulcers/Colitis
☐ Arthritis
☐ Diabetes
☐ Shingles
☐ Kidney problems
☐ Hepatitis
☐ Chemotherapy
☐ Rheumatic fever
☐ Psychiatric problems
☐ Thyroid problems
☐ Surgeries
☐ _____
☐ _____

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

Insurance Information

Health and accident insurance policies are an arrangement between you and your insurance carrier. We will prepare any necessary reports and forms to assist in collecting from the insurance company and any amount authorized to be paid directly to our office will be credited to your account on receipt. You will be responsible for all deductibles, co-pays and co-insurance that apply to your specific policy.

Insurance Co. Name:_____Group #_____

Address:_____ Phone:_____

If you are covered under someone else's insurance policy please provide the following:

Name:_____Insured'd Social Security #:_____

Relationship to patient:_____Date of Birth:_____Employer:_____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he 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.

_____ _____

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** ☐ **Medicaid** ☐ **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.

X-RAY CONSENT

The Doctor has explained that the purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If a non-chiropractic "unusual finding" is discovered when the Doctor reviews the x-rays, I will be informed. I must then determine if I should seek the services of an additional healthcare provider for advice, diagnosis, or treatment of the "unusual finding." I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

I fully understand this consent to chiropractic spinal x-rays.

Signature:_____Date:_____