PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name____

Address____

City_____________________________ State______________

Zip ________________Home phone _____________________

Birth date ______________ Cell Phone___________________

Age __________ Gender ________ Number of children _____

Employer____

Work phone ____

Type of work ____

Marital Status _______________________________________

Social Security # _____________________________________

E-mail address_______________________________________

Your e-mail is not shared with any 3rd parties, and is used for general office announcements and promotions.

Payment method ☐ Cash ☐ Check ☐ Credit card

Primary Medical Doctor_________________________________

Hospital_____________________________________

ABOUT THE SPOUSE

Name ____________________________________

Employer _________________________________

Work phone _______________________________

Type of work ______________________________

EXPERIENCE WITH CHIROPRACTIC

Who may we thank for referring?__________________________ __

Have you seen or heard about us in/on: ☐ Paper ☐ Sign ☐ YP

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

Reason for those visits? _________________________________

Doctor's name:____

Approximate date of last visit:___________________________

Has anyone in your family seen a Chiropractor? ☐ Yes ☐ No

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

REASON FOR THIS VISIT

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 your 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 ____

HEALTH HABITS

	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

AWARENESS OF THE CHIROPRACTIC PRINCIPLES

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

GOALS FOR MY CARE

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 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** – Correcting and relieving the cause of the problem as well as the symptom
- ☐ **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.**

MEDICATIONS I NOW TAKE...

☐ Cholesterol medication	☐ Blood pressure medicine
☐ Stimulants	☐ Blood thinners
☐ Tranquilizers	☐ Pain killers (including aspirin)
☐ Muscle relaxers	☐ ____________
☐ Insulin	☐ ____________

Vitamins & Supplements I now take:______________________

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____

____

Please circle the health concern or concerns you may be experiencing now or have experienced in the past. Each area of concern relates to an area of the spine and nerve function.

C1 C2 C3 C4

Headaches
Migraines - Dizziness
Sinus Problems
Allergies - Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

C5 C6 C7 T1

Sore Throat - Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma –Allergies
High Blood Pressure
Heart Conditions

T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis - Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers - Gastritis
Kidney Problems

L1 L2 L3 L4 L5 SACRAL

Constipation - Colitis
Diarrhea - Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

Other:____________

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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

☐ Severe or frequent headaches	☐ Heart surgery/pacemaker
☐ Kidney Problems	☐ Arthritis
☐ Sinus problems	☐ Heart attack/stroke
☐ Shingles	☐ Dizziness
☐ Ulcers / Colitis	☐ Tuberculosis
☐ Asthma	☐ Digestive problems
☐ Loss of sleep	☐ Congenital heart defect
☐ Pain between shoulders	☐ Chemotherapy
☐ High/Low High blood pressure	☐ Hepatitis
☐ Difficulty breathing	☐ Diabetes
☐ Frequent neck pain	☐ Surgeries ___________________
☐ Numbness	☐ Pain in arms/legs/hands

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

AUTHORIZATION FOR CARE

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

______________________________ 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** ☐ **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.

Terms Of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, 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.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, ______________________________ have read and fully understand the above statement.

Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature

______________________________ Date ______________

Witness ______________________________