

PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name _____
Address _____
City _____ State _____
Zip _____ Home phone _____
Birth date _____ Cell Phone _____
Age _____ Gender _____ Number of children _____
Employer _____
Work address _____
Work phone _____
Type of work _____
Marital Status _____
Social Security # _____
E-mail address _____
Payment method Cash Check Credit card

ABOUT THE SPOUSE/ PARTNER

Name _____
Employer _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office _____

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 any adult 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

	Yes	No	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drink coffee, tea or soda?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear:			
<input type="checkbox"/> Heel lifts	<input type="checkbox"/> Sole lifts	<input type="checkbox"/> Inner soles	<input type="checkbox"/> Arch supports

AWARENESS OF CHIROPRACTIC

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

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

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.**

Sore Throat - Stiff Neck

Radiating Arm Pain
Hand/Finger Numbness
Asthma –Allergies

High Blood Pressure

Heart Conditions



C1
C2
C3
C4
C5
C6
C7
T1

Headaches
Migraines - Dizziness
Sinus Problems -
Allergies Fatigue -
Head Colds

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

MEDICATIONS I NOW TAKE...

- Cholesterol medication
- Blood pressure medicine
- Stimulants
- Blood thinners
- Tranquilizers
- Pain killers (including aspirin)
- Muscle relaxers
- _____

Constipation - Colitis
Diarrhea - Gas Pain

Irritable Bowel

Bladder Problems

Menstrual Problems

Low Back Pain

Other: _____

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.

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

- Severe or frequent headaches
- Heart surgery/pacemaker
- Arthritis
- Sinus problems
- Heart attack/stroke
- Shingles
- Dizziness
- Heart murmur
- Kidney problems
- Loss of sleep
- Congenital heart defect
- Diabetes
- Pain between shoulders
- Chemotherapy
- Thyroid problems
- High/Low blood pressure
- Difficulty breathing
- Hepatitis
- Frequent neck pain
- Surgeries _____
- Numbness in Arms/legs/hands
- Alcohol/drug abuse _____

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

Who should receive bills for payment on your account?

Patient Spouse Parent 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.

