(For Office Use Only)

NAME _____

DATE _____

CASE NUMBER _____

PATIENT HEALTH RECORD

Welcome to our Chiropractic Office.

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific chiropractic care.

ABOUT THE PATIENT

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Birthdate _____

Age _____ Gender ❑ M ❑ F Number of Children _____

Employer _____

Work Address _____

Work Phone _____

Type of Work _____

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Social Security # _____

Driver's License # _____

E-Mail Address _____

Payment Method ❑ Cash ❑ Check ❑ Credit Card

Crdt Cd. # _____ Exp. Date _____

ABOUT THE SPOUSE OR PARENT

Name _____

Employer _____

Work Phone _____

Type of Work _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to

❑ Job ❑ Sports ❑ Auto ❑ Fall
❑ Chronic Discomfort ❑ Home injury ❑ 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

Explain _____

Has this condition occurred before? ❑ Yes ❑ No

Explain _____

Have you seen other doctors for this condition? ❑ Yes ❑ No

Dr.'s Name(s) _____

Type of Treatment _____

Results _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

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

AWARENESS OF 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 life? ❑ Yes ❑ No

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 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.

Patient's Signature _____ Date _____

MEDICATIONS I NOW TAKE

- ❒ Nerve Pills
- ❒ Pain Killers (including Aspirin)
- ❒ Muscle Relaxers
- ❒ Blood Pressure Medicine
- ❒ Insulin
- ❒ Stimulants
- ❒ Blood Thinners
- ❒ Tranquilizers
- ❒ _____
- ❒ _____

HEALTH HABITS

	No	Yes	
Do you smoke?	❒	❒	____ packs/day
Do you drink alcohol?	❒	❒	____ drinks/day
Do you drink coffee?	❒	❒	____ cups/day
Do you exercise regularly?	❒ No	❒ Moderate	❒ Daily
Do you wear	❒ Heel Lifts	❒ Sole Lifts	
	❒ Inner Soles	❒ Arch Supports	

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 the Shoulders
- ❒ Frequent Neck Pain
- ❒ Numbness or Pain in Arms/Legs/Hands
- ❒ Lower Back Problems
- ❒ Digestive Problems
- ❒ Ulcers/Colitis
- ❒ Heart Attack/Stroke
- ❒ Congenital Heart Defect
- ❒ Heart Surgery/ Pacemaker
- ❒ Heart Murmur
- ❒ High/Low Blood Pressure
- ❒ Difficulty Breathing
- ❒ Asthma
- ❒ Arthritis
- ❒ Alcohol/Drug Abuse
- ❒ Venereal Disease
- ❒ HIV/Aids
- ❒ Diabetes
- ❒ Tuberculosis
- ❒ Shingles
- ❒ Kidney Problems
- ❒ Hepatitis
- ❒ Cancer
- ❒ Chemotherapy
- ❒ Anemia
- ❒ Rheumatic Fever
- ❒ Psychiatric Problems
- ❒ Thyroid Problems

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.

_____ _____

Patient's 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 ❑ Personal 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 negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

IN AN EMERGENCY, CONTACT:

Name _____

Relationship _____

Work Phone _____

Home Phone _____

ABOUT MY INSURANCE

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.

Insurance Co. Name _____ Group Number (Plan, Local, Policy #) _____

Address _____ Phone _____

ABOUT THE INSURED PERSON

Name _____ Insured's Social Security # _____

Relation _____ Date of Birth _____

Employer _____