ADULT MEMBER HEALTH RECORD

ABOUT YOU

Name: _____

Address: _____

City/State/Zip: _____

Home phone: _____ Cell phone: _____

Email Address: _____

Date of Birth: _____ Age: _____

Marital Status: _____ # of Children: _____

Employer Name: _____

Work Phone: _____ May we call you at work? Y / N

Position / Job Title: _____

Payment Method: ❑ Cash ❑ Check ❑ Credit Card

ABOUT YOUR SPOUSE

Name: _____

Employer: _____

Type of Work: _____

CHIROPRACTIC EXPERIENCE

Whom may we thank for referring you to our office?

_____

Have you seen or heard of our office through (check all that apply):

❑Community Event ❑Newspaper ❑Mailing ❑Yellow Pages ❑Sign

Have you been adjusted by a Chiropractor before? Y / N

What was the reason for the visit? _____

Doctor's Name: _____

Approximate date of last visit: _____

Has any adult in your family ever seen a Chiropractor? Y / N

REASON FOR THIS VISIT

Describe the reason for this visit: _____

_____

_____

Is the purpose of this appointment related to:

❑Job ❑Sports ❑Auto Accident ❑Fall ❑Home Injury ❑Chronic Discomfort ❑Other

Briefly Explain: _____

_____

If job related, have you reported the injury to your employer? ❑ YES ❑ NO

For all other reasons, when did this condition begin?

Date: _____

Has this condition:

❑Gotten worse ❑Stayed the same ❑Come and gone

Does this condition interfere with:

❑Work ❑Sleep ❑Daily Routine ❑Other Activities

Briefly Explain: _____

_____

Has this condition occurred before?

❑ YES ❑ NO

Briefly Explain: _____

_____

Have you seen other Doctors for this condition?

❑ YES ❑ NO

Type of treatment? _____

Results: _____

HEALTH HABITS

DO YOU :

SMOKE?	❑ YES	❑ NO
DRINK ALCOHOL?	❑ YES	❑ NO
DRINK COFFEE, TEA OR SODA?	❑ YES	❑ NO
EXERCISE REGULARLY?	❑ YES	❑ NO

DO YOU WEAR:

❑HEEL LIFTS ❑SOLE LIFTS ❑INNER SOLES ❑ARCH SUPPORTS

Discover Health Chiropractic, PC
1136 W. Divide Ave.
Bismarck, ND 58501

WERE YOU AWARE THAT...

Doctors of Chiropractic work with the Nervous System?
❑ YES ❑ NO

The Nervous System Controls all bodily functions & 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 through life?
❑ YES ❑ NO

GOALS FOR YOUR 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 body. 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***

MEDICATIONS YOU TAKE

❑Cholesterol medication ❑Blood Pressure medication

❑Stimulants ❑Tranquilizers

❑Blood Thinners ❑Insulin

❑Muscle Relaxers ❑Other _____

❑Pain killers (including Aspirin)

Vitamins & Supplements I now take: _____

_____

YOUR CONCERNS

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

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

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

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

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

OTHER SYMPTOMS:

_____

_____

_____

_____

_____

_____

_____

HEALTH CONDITIONS

Please check each of the conditions or diseases that you have now, or have had in the past. While they may seem unrelated to the purpose of the appointment they can affect the overall evaluation, care plan or the possibility of being accepted for care.

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

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.

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.*

Patient's signature:_____ Date:_____

Guardian Signature Authorizing

Care for a Minor Child :_____ Date:_____

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

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 ~ **to eliminate major interference to the expression of the body's innate wisdom**. 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:_____

PREGNANCY RELEASE:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray for evaluation purposes. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Patient's signature:_____ Date:_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient's signature:_____ Date:_____

PATIENT CASE HISTORY

FOR OFFICE USE ONLY

CHIEF CONCERNS:
HISTORY OF CONDITION:
ASSOCIATED SYMPTOMS:
AGGRAVATING FACTORS:
WHAT HAS BEEN DONE TO HELP THIS CONDITION:
PRIOR ILLNESS, SURGERY, ACCIDENTS:
FAMILY HEALTH HISTORY:
OTHER:

☐ SYSTEMS CHECK COMPLETE

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