Adult Confidential Health Profile (13 and up)

PATIENT INFORMATION *(all fields required)*

Name: _____ Age: _____ Sex: Male / Female Date of Birth: _____ /_____ /_____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single / Married / Partnered / Divorced / Widowed Spouse's Name: _____ Number of Children: _____

First Name & Ages:_____

Phones: Home: _____ Cell: _____ Work: _____ Preferred Phone Number: Home / Cell / Work

For confirming appointments, would you prefer? TEXT / EMAIL If text, who is your cell phone carrier? _____

Email: _____ Occupation: _____ Employer: _____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

What is your **#1 concern**? _____ Month & year it started? _____

Have you had it before? Y / N Is it getting better or worse? B / W Is it? [ ] Constant or [ ] Come and Go

What has helped it? _____ What makes it worse? _____

Is it? [ ] Sharp [ ] Dull [ ] Achy [ ] Numb [ ] Tingling [ ] Other? _____

Circle how severe is it? (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How did it begin? [ ] Bending [ ] Lifting [ ] Twisting [ ] Fall [ ] Pushing/Pulling [ ] Car Accident [ ] Unknown

[ ] Other? _____

What is your **#2 concern**? _____ Month & year it started? _____

Have you had it before? Y / N Is it getting better or worse? B / W Is it? [ ] Constant or [ ] Come and Go

What has helped it? _____ What makes it worse? _____

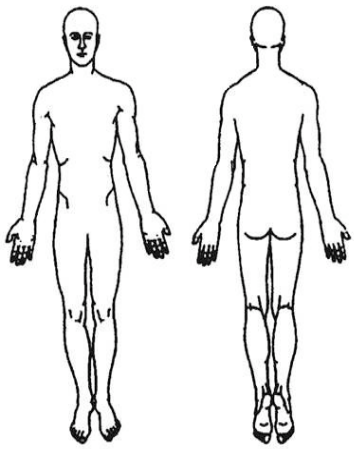
Is it? [ ] Sharp [ ] Dull [ ] Achy [ ] Numb [ ] Tingling [ ] Other? _____

Circle how severe is it? (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How did it begin? [ ] Bending [ ] Lifting [ ] Twisting [ ] Fall [ ] Pushing/Pulling [ ] Car Accident [ ] Unknown

[ ] Other? _____

Put an X at site of symptoms



CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

❑ Check this box if none

DIZZINESS	*HIGH BLOOD PRESSURE*	*URINARY PROBLEMS*	*ARTHRITIS*	*NERVOUSNESS*
HEADACHES	*THYROID PROBLEMS*	*MID BACK PAIN*	*SHOULDER PAIN*	*EPILEPSY*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*ULCERS*	*SCIATICA*	*LIVER PROBLEMS*	*INFERTILITY*
NAUSEA	*NUMBNESS IN ARMS*	*NUMBNESS IN LEGS*	*DEPRESSION*	*GASTRIC REFULX*
TMJ	*NUMBNESS IN HANDS*	*NUMBNESS IN FEET*	*CHEST PAIN*	*ALLERGIES*
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*CHRONIC SINUSITIS*
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	*SEIZURES*
ANXIETY	*STOMACH DISORDERS*	*LEG PAINS*	*KNEE PAIN*	*SPINAL BONE FRACTURES*
STROKE	*CANCER*	*HEART DISEASE*	*SPINAL SURGERY*	*OTHER* _____
SCOLIOSIS	*DIABETES*	*FIBROMYALGIA*	*BEDWETTING*	_____

Have you seen any other healthcare providers for these conditions? Yes / No *If yes, what type of care, who, and when? _____

_____

List all fractures, surgical operations and the corresponding years:_____

_____

List ALL over the counter & prescription medications and why you are taking them: _____

_____

How many car accidents have you had and when was the last? _____ Any other TRAUMA? _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, the severity or cause of my health concern. If the patient is a child, please write the child's name here: _____

Patient Signature (or guardian if applicable): _____ **Date:** _____

FAMILY HEALTH HISTORY

SOME HEALTH PROBLEMS COMMONLY OCCUR IN MULTIPLE MEMBERS OF THE SAME FAMILY. THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING A COMPREHENSIVE REVIEW OF YOUR FAMILY'S CURRENT AND PAST HEALTH HISTORY.

_____ _____

DATE PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
THYROID PROBLEMS					
TMJ					
*NOT ABOVE (LIST BELOW)					

INSURANCE INFORMATION **(NO CHARGES WILL OCCUR WITHOUT YOUR PERMISSION)*

PRIMARY INSURANCE CARRIER: _____ Insured Social: _____

Name of Insured _____ Insured Date of Birth _____

IF APPLICABLE:

SECONDARY INSURANCE CARRIER: _____ Insured Social: _____

Name of Insured _____ Insured Date of Birth _____

- Consultation- includes practice member history. This service is complimentary.
- Assessment/Evaluation (new or established practice member)- includes one or more of the following: range of motion, motion and/or static palpation, leg check, functional assessment, and orthopedic exam. $100 maximum.
- Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand/instrument. $40 maximum.
- X-rays- Specific x-ray views will be taken if necessary to evaluate the current state of your spine. These can also be used to indicate progress after a period of care. $56 per series maximum.

Release of Authorization/Assignment of Benefits & *Notice of Privacy Practices Acknowledgement*

I understand that I may receive a statement of services received and paid for to submit to my insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact he practice at any time to obtain a current copy of the Notice of Privacy Practices.

Terms of Acceptance & Consent to Care

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes (dysafferentation).
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. SOME HAVE BEEN TOLD THERE IS A RISK OF STROKE; HOWEVER, RESEARCH SHOWS YOU ARE JUST AS LIKELY TO HAVE A STROKE LEAVING A MEDICAL DOCOTOR'S OFFICE. NECK ADJUSTMENTS HAVE BEEN SHOWN TO PUT NO MORE STRESS ON THE VERTEBRAL ARTERY THAN WHEN YOU ROTATE YOUR HEAD TO ONE SIDE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

By my signature below, I have read and fully understand the above statements: the release of benefits, notice of privacy practices, terms of acceptance, and the consent to care. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____	_____	_____
Patient Name (printed)	**Signature (if applicable of guardian)**	**Date**