Adult Member Health Record

ABOUT YOU

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

DATE OF BIRTH: | AGE:

MARITAL STATUS: | GENDER:

NUMBER OF CHILDREN & AGES:

EMERGENCY CONTACT NAME:

PHONE:

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PEOPLE SEE CHIROPRACTORS FOR A VARIETY OF REASONS. PLEASE CHECK ONE BOX SO THAT WE MAY BE GUIDED BY YOUR WISHES WHEN POSSIBLE.

- o PATCH CARE: SYMPTOMATIC RELIEF OF PAIN OR DISCOMFORT
- o CORRECTIVE CARE: PAIN RELIEF, FOLLOWED BY CARE TO CORRECT DYSFUNCTIONS FOUN D ON THE INSIGHT SCAN.
- o WELLNESS CARE: CORRECTIVE CARE FOLLOWED BY REGULAR ADJUSTMENTS TO KEEP YOUR HEALTH MOVING TOWARD OPTIMAL FUNCTION!

REASON FOR THIS VISIT

REASON FOR THIS VISIT (PLEASE CIRCLE):
PAIN COMPLAINT AUTO/JOB INJURY WELLNESS

PLEASE DESCRIBE:

WHAT DATE DID THIS BEGIN?

DID THIS PROBLEM START:
SUDDENLY GRADUALLY AFTER AN INJURY

HAS THIS CONCERN BECOME:
BETTER WORSE CHRONIC COMES AND GOES

WHAT MAKES THE PROBLEM BETTER?

WHAT MAKES THE PROBLEM WORSE?

DOES THIS CONCERN INTERFERE WITH:
WORK SLEEP DAILY ROUTINE OTHER ACTIVITIES

PLEASE EXPLAIN:

PLEASE DESCRIBE THE QUALITY OF THE PAIN (SHARP, DULLY ACHY, ETC.)

DOES THE PAIN RADIATE? YES NO
TO WHERE?:

RATE THE SEVERITY OF THE PAIN (0=NO PAIN, 10=E.R. VISIT):

DOES THE PAIN CHANGE THROUGHOUT THE DAY? YES NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS COMPLAINT? YES NO

DOCTOR'S NAME AND TYPE OF TREATMENT:

RESULTS: GOOD BAD INDIFFERENT

HAVE YOU HAD X-RAYS OR ANY OTHER IMAGING? YES NO

""""""""""""MEDICAL HISTORY

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?

DOCTOR NAME AND DATE OF LAST VISIT:

PLEASE LIST ANY DIAGNOSED DISEASES:

PLEASE LIST ANY CAR ACCIDENTS, BROKEN BONES OR OTHER TRAUMA:

PLEASE LIST ANY SURGERIES WITH APPROXIMATE DATES:

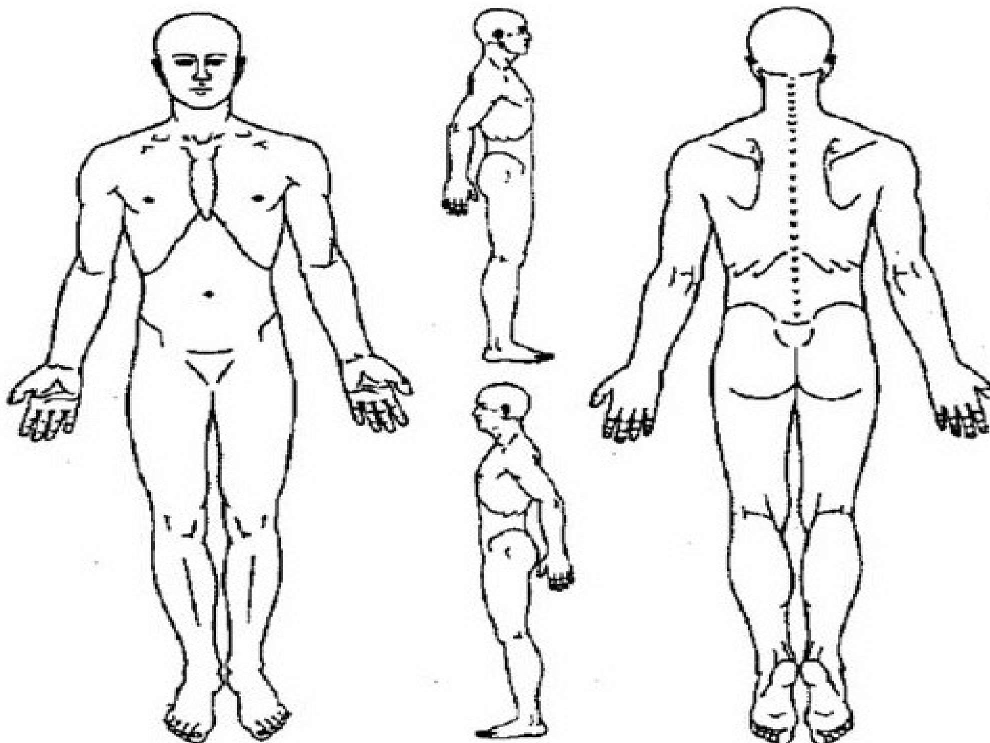
CURRENT MEDICATIONS

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS:

PAIN DIAGRAM

PLEASE MARK THE AREA OF INJURY OR DISCOMFORT ON THE CHART BELOW, USING THE APPROPRIATE SYMBOLS.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING
- - - - - - - - - -	O O O O O O O O O	^ ^ ^ ^ ^ ^ ^ ^	X X X X X
- - - - - - - - - -	O O O O O O O O O	^ ^ ^ ^ ^ ^ ^ ^	X X X X X
- - - - - - - - - -	O O O O O O O O O	^ ^ ^ ^ ^ ^ ^ ^	X X X X X



FEMALE PATIENTS

ARE YOU (PLEASE CIRCLE):
CYCLING MONTHLY   PERIMENOPAUSAL   MENOPAUSAL

ARE YOU CURRENTLY PREGNANT?   YES   NO

IF YES, HOW FAR ALONG? ____________ WEEKS

DUE DATE: _________________________________

ARE YOU CURRENTLY BREASTFEEDING?   YES   NO

DO YOU (PLEASE CIRCLE):

EXPERIENCE PAINFUL PERIODS?   YES   NO

EXPERIENCE IRREGULAR CYCLES?   YES   NO

EXPERIENCE INFERTILITY?   YES   NO

OTHER CONCERNS

PLEASE LIST ANY OTHER CONCERNS YOU HAVE.

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT POLICY

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

By signing below I agree to the above and allow the doctor, affiliated with ABC Family Chiropractic, to perform such. This consent will cover the entire course of my treatment.

Patient Name: ______________________________ ***Date:***____________

Patient or Guardian Signature:______________________________ ***Date:***____________

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.

PATIENT SIGNATURE ______________________________ **DATE**____________

FINANCIAL POLICY

PATIENTS WITH INSURANCE*:* *We will bill your insurance for services rendered in the office. We will verify benefits prior to receiving care, however,* ***a quote of benefits is never a guarantee of coverage.*** *We will collect 100% of services not covered by your insurance. If you have a copay, co-insurance or unmet deductible, you will be responsible for payment at the time of service.* **PATIENTS WITH MEDICARE*: Medicare Part B only covers manipulation of the spine.*** *All other services are not covered and are your responsibility. You will be required to meet your annual deductible and pay 20% of the allowed fee on spinal manipulations including 100% of non covered services. Medicare Part B supplemental policies do not pay for services that are not allowed by Medicare. Medicare patients will be required to sign an Advanced Beneficiary Notice prior to starting care, anytime there is a significant change in diagnoses or at the beginning of each year.* **PRIVATE PAY (CASH)*:*** *You will be required to pay for your services at the time they are rendered.*

I have read and understand the financial policy of ABC Family Chiropractic. I also understand that I am ultimately responsible for all services not paid by insurance or third party. Should there be a balance left at the end of my treatment, I will receive an invoice for the amount owed and pay it promptly, or call the office to make payment arrangements.

PATIENT 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. I also allow use of my personal email address for office communication.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: