APPLICATION FOR CARE

Adult Health Record

HR # ___________

PATIENT DEMOGRAPHICS

NAME:

ADDRESS:

CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:

EMAIL ADDRESS:

PREFERRED METHOD OF COMMUNICATION:
❑ EMAIL ❑ PHONE ❑ MAIL

DATE OF BIRTH:	AGE:
GENDER: ❑ MALE ❑ FEMALE	MARITAL STATUS: ❑ SINGLE ❑ MARRIED
SOCIAL SECURITY NUMBER:	NUMBER OF CHILDREN:

RACE: ❑ AMERICAN INDIAN or ALASKA NATIVE ❑ ASIAN
❑ BLACK or AFRICAN AMERICAN ❑ WHITE (CAUCASIAN)
❑ OTHER ❑ I DECLINE TO ANSWER

ETHNICITY: ❑ HISPANIC or LATINO ❑ NOT HISPANIC OR LATINO
❑ I DECLINE TO ANSWER

EMPLOYER:

OCCUPATION:

EMPLOYER ADDRESS:

EMPLOYER CITY/STATE:	WORK PHONE:

EMERGENCY CONTACT:

RELATIONSHIP:	PHONE NUMBER:

SPOUSE'S NAME:

SPOUSE'S EMPLOYER:

SPOUSES'S OCCUPATION:

DO YOU HAVE HEALTH INSURANCE: ❑ YES ❑ NO

Date: __________

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HOW HAVE YOU SEEN OR HEARD OF OUR OFFICE (√ ALL THAT APPLY)
❑ NEWSPAPER ❑ SIGN ❑ INTERNET ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE: ❑ YES ❑ NO

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HISTORY OF COMPLAINT

PLEASE IDENTIFY THE CONDITION(S) THAT BROUGHT YOU TO THIS OFFICE:
PRIMARY: ____
SECOND: ____
THIRD: ____
FOURTH: ____

ON A SCALE OF **1** TO **10** WITH **10** BEING THE WORST PAIN AND **ZERO** BEING NO PAIN, RATE YOUR ABOVE COMPLAINTS BY **CIRCLING THE NUMBER**:
PRIMARY COMPLAINT IS: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
SECOND COMPLAINT IS: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
THIRD COMPLAINT IS: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
FOURTH COMPLAINT IS: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

WHEN DID THE PROBLEM(S) BEGIN?

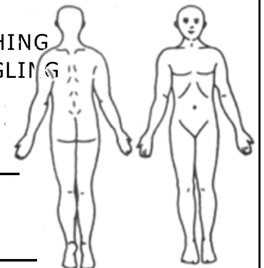
WHEN IS THE PROBLEM(S) AT ITS WORST?
❑ AM ❑ PM ❑ MID-DAY ❑ LATE PM

HOW LONG DOES IT LAST? ❑ CONSTANT **or**
❑ ON AND OFF DURING DAY **or** ❑ COMES AND GOES THROUGHOUT WEEK

HOW DID THE PROBLEM HAPPEN?

CONDITION(S) EVER BEEN TREATED BY ANYONE IN THE PAST?
❑ NO ❑ YES **IF YES,** WHEN:__________ BY WHOM:________________
HOW LONG WERE YOU UNDER CARE:______________________________
WHAT WERE THE RESULTS?____________________________________

PLEASE MARK THE AREAS ON THE DIAGRAM WITH THE FOLLOWING **LETTERS** TO DESCRIBE YOUR SYMPTOMS:
R=**R**ADIATING **B**=**B**URNING **D**=**D**ULL **A**=**A**CHING
N=**N**UMBNESS **S**=**S**HARP/STABBING **T**=**T**INGLING



WHAT RELIEVES YOUR SYMPTOMS?
____

WHAT MAKES YOUR SYMPTOMS FEEL WORSE?
____

IS THIS PROBLEM THE RESULT OF **ANY** TYPE OF ACCIDENT: ❑ YES ❑ NO

HEALTHY CHOICE
FAMILY CHIROPRACTIC

Name: ________________________ HR #_____________________ Date: _________________

PAST HISTORY

HAVE YOU SUFFERED WITH ANY OF THIS OR A SIMILAR PROBLEM IN THE PAST?

❑ NO ❑ YES **IF YES,** HOW MANY TIMES?_______________________

WHEN WAS THE LAST EPISODE?_______________________

HOW DID THE INJURY HAPPEN?_______________________

PLEASE IDENTIFY ANY AND ALL TYPES OF JOBS YOU HAVE HAD IN THE PAST THAT HAVE IMPOSED ANY PHYSICAL STRESS ON YOU OR YOUR BODY:

____

IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS, PLEASE INDICATE WITH A **P** FOR IN THE ***PAST***, **C** FOR ***CURRENTLY*** HAVE OR **N** FOR ***NEVER*** HAVE HAD:

____ BROKEN BONE	____ DISLOCATIONS	____ TUMORS
____ LOSS OF BALANCE	____ FRACTURE	____ DISABILITY
____ CANCER	____ HEART ATTACK	____ OSTEO ARTHRITIS
____ DIABETES	____ CEREBRAL VASCULAR	____ HEADACHE
____ HEADACHE	____ PREGNANT	____ DIZZINESS
____ PROSTATE PROBLEMS	____ ULCERS	____ NECK PAIN
____ FREQUENT COLDS/FLU	____ RHEUMATOID ARTHRITIS	____ IMPOTENCE/SEXUAL DYSFUNCTION
____ HEARTBURN	____ JAW PAIN/TMJ	____ BLURRED VISION
____ FAINTING	____ DIGESTIVE PROBLEMS	____ HEART PROBLEMS
____ SHOULDER PAIN	____ TREMORS	____ DOUBLE VISION
____ MENOPAUSAL PROBLEMS	____ HIGH BLOOD PRESSURE	____ LOW BLOOD PRESSURE
____ PAIN WITH COUGH/SNEEZE	____ CONVULSIONS/ EPILEPSY	____ DIARRHEA/ CONSTIPATION
____ UPPER BACK PAIN	____ MID BACK PAIN	____ CHEST PAIN
____ RINGING IN EARS	____ COLON TROUBLE	____ ASTHMA
____ LOW BACK PAIN	____ HIP PAIN	____ HEARING LOSS
____ MENSTRUAL PROBLEMS	____ DIFFICULTY BREATHING	____ FOOT/KNEE PROBLEMS
____ BACK CURVATURE	____ DEPRESSION	____ PMS
____ GALL BLADDER TROUBLE	____ SINUS/DRAINAGE PROBLEMS	____ SWOLLEN/PAINFUL JOINTS
____ IRRITABLE	____ BED WETTING	____ KIDNEY TROUBLE
____ SCOLIOSIS	____ SKIN PROBLEMS	____ MOOD CHANGES
____ LEARNING DISABLITY	____ LUNG PROBLEMS	____ EATING DISORDER
____ ADD/ADHD	____ NUMB/TINGLING ARMS/HANDS/FINGERS	____ NUMB/TINGLING LEGS/FEET/TOES
____ LIVER TROUBLE	____ ALLERGIES	____ TROUBLE SLEEPING
____ HEPATITIS (A,B,C)	____ OTHER SERIOUS CONDITIONS:______________	

PLEASE IDENTIFY ALL PAST AND ANY **CURRENT** CONDITIONS YOU FEEL MAY BE CONTRIBUTING TO YOUR PRESENT PROBLEM:

	HOW LONG AGO	TYPE OF CARE	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT			

HEALTH HABITS

SMOKING: ❑ CIGARS ❑ PIPE ❑ CIGARETTES ❑ FORMER SMOKER
HOW OFTEN? ❑ DAILY ❑ WEEKENDS ❑ OCCASIONALLY ❑ NEVER

ALCOHOLIC BEVERAGE: CONSUMPTION OCCURS
❑ DAILY ❑ WEEKENDS ❑ OCCASIONALLY ❑ NEVER

RECREATIONAL DRUG USE:
❑ DAILY ❑ WEEKENDS ❑ OCCASIONALLY ❑ NEVER

DO YOU EXERCISE AT LEAST 3 TIMES/WEEK? ❑ YES ❑ NO

DO YOU DRINK AT LEAST 64 OUNCES OF WATER/DAY? ❑ YES ❑ NO

SUPPLEMENTS AND MEDICATIONS

LIST PRESCRIPTION AND NON-PRESCRIPTION DRUGS YOU TAKE:

____
____
____
____

DO YOU HAVE ANY MEDICATION ALLERGIES? ❑ NO ❑ YES
IF YES WHAT MEDICATION AND REACTION:

____

LIST VITAMINS AND SUPPLEMENTS YOU TAKE:

____
____
____

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY SUFFER WITH THE SAME CONDITION(S)?
❑ NO ❑ YES **IF YES WHOM:** ❑ GRANDMOTHER ❑ GRANDFATHER ❑ MOTHER ❑ FATHER ❑ SISTER(S) ❑ BROTHER(S) ❑ SON(S) ❑ DAUGHTER(S)

HAVE THEY EVER BEEN TREATED FOR THEIR CONDITION?
❑ NO ❑ YES ❑ I DON'T KNOW

ANY OTHER HEREDITARY CONDITIONS THE DOCTOR SHOULD BE AWARE OF? ❑ NO ❑ YES:

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO HEALTHY CHOICE FAMILY CHIROPRACTIC FOR ALL BENEFITS WHICH MAY BE PAYABLE UNDER A HEALTHCARE PLAN OR FROM ANY OTHER COLLATERAL SOURCES. I AUTHORIZE UTILIZATION OF THIS APPLICATION OR COPIES THEREOF FOR THE PURPOSE OF PROCESSING CLAIMS AND EFFECTING PAYMENTS, AND FURTHER ACKNOWLEDGE THAT THIS ASSIGNMENT OF BENEFITS DOES NOT IN ANY WAY RELIEVE ME OF PAYMENT LIABILITY AND THAT I WILL REMAIN FINANCIALLY RESPONSIBLE TO HEALTHY CHOICE FAMILY CHIROPRACTIC FOR ANY AND ALL SERVICES I RECEIVE AT THIS OFFICE.

________________________________ _____/_____/________
PATIENT OR AUTHORIZED PERSON'S SIGNATURE **DATE COMPLETED**

________________________________ _____/_____/________
DOCTOR'S SIGNATURE **DATE REVIEWED**

Name: __________________________ HR #_______________________ Date: ___________________

ACTIVITIES OF LIFE

PLEASE IDENTIFY HOW YOUR CURRENT CONDITION IS AFFECTING YOUR ABILITY TO CARRY OUT ACTIVITIES THAT ARE ROUTINELY PART OF YOUR LIFE:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climb Stairs	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lift Children/Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Read/Concentrate	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Getting Dressed	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sexual Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Static Sitting	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Static Standing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard Work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Washing/Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sweeping/Vacuuming	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dishes	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Laundry	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Garbage	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Other:_______________	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

❑ **I chose to decline receipt of my clinical summary after every visit** (*These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:____ Date:_____/_____/____________

For office use only

Height:__________ Weight:__________ Blood Pressure:_______/_______

Name: _______________________ HR #____________________ Date: ________________

HEALTHY CHOICE FAMILY CHIROPRACTIC

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of a disc condition or minor fractures have been associated with chiropractic adjustments. Very rarely (between one instance per one to two million) stroke has also been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Healthy Choice Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ _____/_____/_____ Witness Initials

Patient or Authorized Person's Signature *Date*

REGARDING: X-rays/Imaging Studies

FEMALES ONLY *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk for further explanation.*

❑ The first day of my last menstrual cycle was on _____/_____/_____ (Date)

❑ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ _____/_____/_____ *Witness Initials*

Patient or Authorized Person's Signature *Date*

MEDICAL INFORMATION RELEASE FORM (HIPAA)

NAME:____ **DATE OF BIRTH:**_____/_____/_____

RELEASE OF INFORMATION:

❑ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

❑ Name____Relationship____________________

❑ Information is not to be released to anyone

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES:

Please call ❑ my home ❑ my work ❑ my mobile number:_________________________

If unable to reach me:

❑ you may leave a detailed message

❑ please leave a message asking me to return your call

❑ ____

The best time to reach me is (day)__________________ between (time)________________

____ _____/_____/_____ *Witness Initials*

Patient or Authorized Person's Signature *Date*