

APEX FAMILY CHIROPRACTIC ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	GENDER:
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:
SPOUSE DATE OF BIRTH:

HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per day _____
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per week _____
DO YOU DRINK COFFEE, TEA, OR SODA	If yes, how much per day _____
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU WEAR:	
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS	

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> JOB <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

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

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 for my condition.**

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS (INCLUDING ASPIRIN)
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER:
<input type="checkbox"/> INSULIN	<input type="checkbox"/> OTHER:
<input type="checkbox"/> VITAMINS & SUPPLEMENTS:	

YOUR CONCERNS

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

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



C1 Headaches
C2 Migraines
C3 Dizziness
C3 Sinus Problems
C4 Allergies
C4 Fatigue
C5 Head Colds
C6 Vision Problems
C7 Difficulty Concentrating
T1 Hearing Problems

T2
T3 Middle Back Pain
T4 Congestion
T5 Difficulty Breathing
T6 Bronchitis
T6 Pneumonia
T7 Gallbladder Conditions
T8 Stomach Problems
T9 Ulcers
T10 Gastritis
T11 Kidney Problems
T12

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

OTHER:

HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have 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.

<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/ LEGS/HANDS	<input type="checkbox"/> NUMBNESS	FOR WOMEN ONLY:
<input type="checkbox"/> HEART SURGERY/ PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	<i>DO YOU:</i> EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	

LOSS OF WELLNESS

<u>BIRTH — AGE 5</u>	<u>COMMENTS</u>	<u>BIRTH — PRESENT</u>	<u>COMMENTS</u>
DID YOUR MOTHER:		HAVE YOU:	
SMOKE OR DRINK ALCOHOL?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	HAD ANY TRAUMAS?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
HAVE A PROPER DIET?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	EVER BEEN IN ACCIDENTS?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
EXERCISE DURING PREGNANCY?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	HAD SURGERY AND	
EXPERIENCE ANY FALLS		ORGANS REMOVED/REPLACED?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
AND INJURIES DURING PREGNANCY?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	HAD THE RECOMMENDED	
EXPERIENCE ANY PHYSICAL AND/OR		SCHEDULED VACCINATIONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
MENTAL ABUSE?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	ANY CHILDHOOD SICKNESSES?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
BIRTH PROCESS:		FALLEN DOWN THE STAIRS?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
WAS THE DELIVERY LONG?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	PLEASE USE THIS SPACE FOR ANY ADDITIONAL COMMENTS:	
WAS THE DELIVERY DIFFICULT?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	
FORCEPS?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	
CAESAREAN?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	
BREACH/CEPHALIC?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	
HOME BIRTH?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	
HOSPITAL BIRTH?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	
MOTHER GIVE DRUGS DURING DELIVERY?	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	
WAS LABOR INDUCED?	<input type="checkbox"/> YES <input type="checkbox"/> 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.*

SIGNATURE:	DATE:
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GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:
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WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

PATIENT
 SPOUSE
 PARENT
 WORKERS COMP
 AUTO INSURANCE
 MEDICARE
 HEALTH INSURANCE

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

INFORMED CONSENT

Welcome to Apex Family Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment, therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed in consenting to treatment.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE- *Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when it occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 per 10 million treatments. The most recent studies (Journal of the CCA, Vol.37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.*

SORENESS- *Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.*

SOFT TISSUE INJURY- *Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon or other soft tissue injury.*

RIB INJURY- *Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.*

PHYSICAL THERAPY BURNS- *Heat Generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic promptly.*

OTHER PROBLEMS- *There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.*

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

HAVING CAREFULLY READ THE ABOVE, I HEARBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

SIGNATURE:	DATE:
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