ADULT MEMBER HEALTH RECORD

ABOUT YOU

Name:	
Address:	
City:	State/Zip:
Home Phone:	Cell Phone:
Email:	
Date of Birth:	Age:
Social Security #:	Gender:
Marital Status:	Number of Children:
Employer:	Address:
Work Phone:	Position:

EMERGENCY CONTACT

Emergency Contact Name:
Emergency Contact Number:
Relation to You:

HEALTH HABITS

Do you smoke? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Do you drink caffeinated beverages (coffee, tea, soda, etc.)? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No
Do you wear any of the following? ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

MEDICATIONS

Cholesterol:	Insulin:
Stimulants:	Pain Killers:
Tranquilizers:	Blood Pressure:
Muscle Relaxers:	Other:

CHIROPRACTIC EXPERIENCE

How did you hear about our office? (Check all that apply) ☐ Friend/Family Member ☐ Health Care Provider ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Mailing ☐ Internet ☐ Community Event
Who referred you to our office?
Have you ever been adjusted by a chiropractor before? ☐ Yes ☐ No
If yes, what was the reason for stopping care?
Doctor's Name:
Approximate date of last visit:
Has any member of your family ever seen a chiropractor before? ☐ Yes ☐ No

REASON FOR VISIT

Describe the reason for this visit: ☐ Wellness ☐ Sports ☐ Auto Injury ☐ Fall ☐ Home Injury ☐ Work Injury ☐ Chronic Discomfort ☐ Other
Briefly describe how this has impacted your overall life:
When did this concern begin?
Has this concern: ☐ Gotten Worse ☐ Stayed Constant ☐ Come and Gone
Does this concern interfere with any of the following?: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities
Has this concern occurred before? ☐ Yes ☐ No
Have you seen other doctors for this concern? ☐ Yes ☐ No
If yes, doctor's name:
Type of treatment:
Results:

SUPPLEMENTS

Fish Oils (Omega 3's):	Probiotic:
Multivitamin:	Other:
Calcium/Magnesium	Other:
Vitamin C:	Other:

HEALTH HISTORY

☐ severe/frequent head-aches	☐ thyroid problems	☐ pain in arms/legs/ hands	☐ numbness	**WOMEN ONLY**
☐ heart surgery/ pacemaker	☐ sinus problems	☐ low blood pressure	☐ allergies	Are you pregnant? ☐ Yes ☐ No
☐ lower back problems	☐ hepatitis	☐ rheumatic fever	☐ diabetes	If yes, when is your due date? _____
☐ digestive problems	☐ difficulty breathing	☐ ulcers/colitis	☐ surgeries	Are you nursing? ☐ Yes ☐ No
☐ pain between shoulders	☐ kidney problems	☐ Tuberculosis	☐ asthma	Are you taking birth control? ☐ Yes ☐ No
☐ congenital heart defect	☐ high blood pressure	☐ arthritis	☐ loss of sleep	Do you: Experience painful periods? ☐ Yes ☐ No
☐ frequent neck pain	☐ chemotherapy	☐ shingles	☐ dizziness	Have irregular cycles? ☐ Yes ☐ No
Please list all surgeries you've had:				Have breast implants? ☐ Yes ☐ No

STRESS HISTORY

HISTORY OF PHYSICAL STRESS

BIRTH STRESS: Research indicates that the birth process can cause trauma to a baby's spine and nervous system. Please indicate to the best of your knowledge how YOU were birthed:

☐ Drug Induced	☐ C-Section	☐ Breech	☐ Natural	☐ Forceps
☐ Prolonged	☐ Cord Around Neck	☐ At Home	☐ In Hospital	☐ Suction

GENERAL PHYSICAL TRAUMA

Have you had any accidents related to the following (check all that apply and give dates):
☐ Automobile (even as passenger) _____ ☐ Motorcycle _____ ☐ Bicycle _____ ☐ Sports _____

Have you ever injured your spine (head, back, neck, hips)? ☐ Yes ☐ No

Have you ever broken any bones or sprained any part of your body? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

HISTORY OF CHEMICAL STRESS

Chemical stresses occur during life due to any substance that is inhaled, injected, taken by mouth, or on the skin that is toxic to the body (food allergies, drug reactions, exposure to chemicals in the air, etc.). The following will give us insight into any exposures you may have had.

Have you ever been vaccinated? ☐ Yes ☐ No

Do you or have you ever taken… ☐ Prescription Drugs ☐ Over the counter drugs ☐ Recreational Drugs

Have you been exposed to… ☐ Chemicals ☐ Fumes ☐ Dust ☐ Smoke

Please list current medications:

Any medications previously taken for more than 6 months? ☐ Yes ☐ No

HISTORY OF EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate (if you are comfortable sharing) if you have experienced any of the emotional stresses below.

☐ Childhood Trauma	☐ Loss of loved one	☐ Relationship Stress
☐ Work or School Stress	☐ Divorce/Separation	☐ Financial Stress
☐ Lifestyle Change	☐ Illness	☐ Family Stress

GOALS & CONCERNS

YOUR CONCERNS

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CHECK any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

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 would like the Doctor to select the type of care for my condition.

ARE YOU AWARE THAT…

The nervous system controls all bodily functions and systems? ☐ Yes ☐ No

Doctors of chiropractic work with the nervous system? ☐ Yes ☐ No

Chiropractic is the largest natural healing profession in the world? ☐ Yes ☐ No

☐Headaches	C1
☐Migraines	C2
☐Dizziness	C3
☐Sinus Problems	C5
☐Fatigue	C6
☐Head Colds	C7
☐Vision Problems	
☐Difficulty Concentrating	
☐Hearing Problems	
☐Sore Throat	
☐Stiff Neck	
☐Radiating Arm Pain	
☐Hand/Finger Numbness	T2
☐Asthma	T3
☐Allergies	T4
☐High Blood Pressure	T5
☐Heart Conditions	T6
☐Middle Back Pain	T7
☐Congestion	T9
☐Difficulty Breathing	
☐Bronchitis/Pneumonia	
☐Gallbladder Conditions	
☐Stomach Problems	
☐Ulcers	
☐Gastritis	
☐Constipation	
☐Colitis	L1
☐Diarrhea	L2
☐Irritable Bowel	L3
☐Bladder Problems	L4
☐Menstrual Problems	L5
☐Low Back Pain	
☐Pain or Numbness in legs	
☐Reproductive Problems	SAC
☐Other:	

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

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 Lifestyle 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.
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.

Sign if read above:_____ Date:_____

NOTICE OF PRIVACY POLICY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not to be done, place a check in the box next to anything you refuse and initial.
We may need to contact you by telephone or text at home or at work regarding appointments and other matters related to care/appointments in this office.

- We may need to leave a message with another person (spouse, co-worker) or on an answering machine/ voicemail at home or at work regarding appointments and other matters related to care in this office.

- We routinely have mailings (including postcards) from our office sent to you at home or email address.

- 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:_____