Patient Health Record

Name:_____ Today's Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Telephone ( )_____ Work ( )_____ Cell ( ) _____
Email:_____
Male:_____ Female:_____ Birthday:_____ Age:_____
Single:_____ Married:_____ Spouse's Name:_____
Occupation:_____ Employer:_____
Have you seen a Chiropractor before? YES NO If yes, when:_____
Whom may we thank for referring you to our office?_____

Your Health Summary

Have now / Have had in the past 3 months

- ☐/☐ Headaches
- ☐/☐ Pins and Needles in arms/legs
- ☐/☐ Dizziness
- ☐/☐ Fatigue
- ☐/☐ Sleeping Problems
- ☐/☐ Cold Sweats
- ☐/☐ Mood Swings
- ☐/☐ Buzzing of the ears
- ☐/☐ Numbness in toes
- ☐/☐ Depression
- ☐/☐ Neck Stiff
- ☐/☐ Constipation
- ☐/☐ Lights bother eyes
- ☐/☐ Menstrual Pain

Have now / Have had in the past 3 months

- ☐/☐ Fainting
- ☐/☐ Back Pain
- ☐/☐ Ringing in the ears
- ☐/☐ Irritability
- ☐/☐ Cold Hands/Feet
- ☐/☐ Fever
- ☐/☐ Problem urinating
- ☐/☐ Menstrual irregularity
- ☐/☐ Neck Pain
- ☐/☐ Loss of Balance
- ☐/☐ Upset Stomach
- ☐/☐ Tension
- ☐/☐ Hot Flashes
- ☐/☐ Heartburn

What is the reason you are being seen for today? _____

When did the condition you are coming on for begin? _____

Health Insurance Information: **(Please give card to staff)**

Insurance Carrier_____ Relationship to Insured: Self Spouse Parent Other

If not the insured please complete:

Name of Insured_____ Date of Birth_____

If Auto or Workman's Comp. Please complete:

Auto Ins. Co. _____Policy # _____Claim#_____

Agent's Name _____ Phone #_____

Informed Consent

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Disc Herniations: Disk herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes herniations in both the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This usually occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis in their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

Stroke: Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only: this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA. Vol. 37 No.2, June 1993) estimates that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before he/she would statistically be associated with a single patient stroke.

Other problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

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, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

Please feel free to ask us any questions you may have. When you have a full understanding of the above, please sign and date below.

_____
Patient Name Printed

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature for a Minor Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care; it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's ability to correct vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being - NOT merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes an alteration of nerve function and interference to the transmission of mental impulses, resulting in a reduction of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if in the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of body function and optimum health. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

_____ _____
(Signature) (Date)

Parents, please complete:

Consent to evaluate and treat a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature Date

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPPA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature: _____ Date:_____

Restrictions:

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: _____ Date:_____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Total Score _____
PRINTED

_____ _____
Signature Date