ADVANCED CHIROPRACTIC

ADULT HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
CELL PHONE:	HOME PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE: GENDER:

❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

PLEASE LIST YOUR CHILDREN'S NAME & AGE

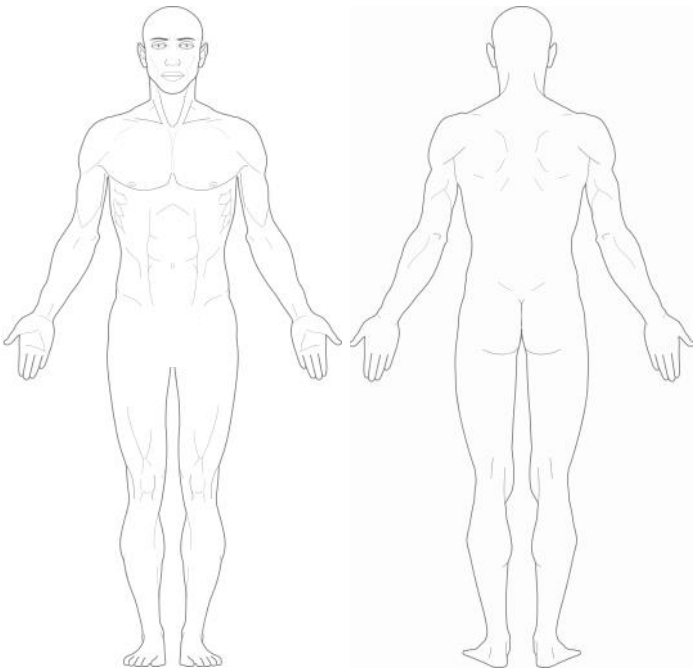
NAME:	AGE:	NAME:	AGE:
NAME:	AGE:	NAME:	AGE:
NAME:	AGE:	NAME:	AGE:

EMPLOYER NAME:	
WORK PHONE:	OCCUPATION:
SPOUSE NAME:	SPOUSE EMPLOYER:

Appointment Reminders: ❑ Text ❑ Email ❑ No Reminders

INSTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling
S=Stiffness/Soreness



CHIROPRACTIC EXPERIENCE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

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

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME: APPROX DATE OF LAST VISIT:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ WELLNESS ❑ CHRONIC DISCOMFORT ❑ HOME INJURY ❑ FALL
❑ SPORTS ❑ WORKERS COMPENSATION ❑ OTHER

PLEASE EXPLAIN:

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER?
❑ YES ❑ NO ❑ N/A

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES

HAS THIS CONDITION OCCURRED BEFORE? ❑ YES ❑ NO

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

MEDICATIONS YOU TAKE

❑ CHOLESTEROL MEDICATIONS	❑ BLOOD PRESSURE MEDICATIONS
❑ ANTI-DEPRESSANT	❑ BLOOD THINNERS
❑ SLEEP AID	❑ PAIN KILLERS AND ASPIRIN
❑ MUSCLE RELAXERS	❑ OTHER:
❑ INSULIN	❑ OTHER:

HEALTH HABITS

DO/DID YOU SMOKE?	❑ YES	❑ NO	If yes, how much per day_____
DO/DID YOU DRINK ALCOHOL?	❑ YES	❑ NO	If yes, how much per week_____
DO YOU DRINK COFFEE, TEA, OR SODA	❑ YES	❑ NO	If yes, how much per day_____
DO YOU EXERCISE REGULARLY?	❑ YES	❑ NO	
DO YOU WEAR: ❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS			
DO YOU GET RESTFUL SLEEP? HOW MANY HOURS PER NIGHT? _____	❑ YES	❑ NO	
DO YOU TAKE A DAILY VITAMIN OR SUPPLEMENT?	❑ 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.

❑ **Corrective care:** Symptomatic relief of pain or discomfort.

❑ **Relief 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.

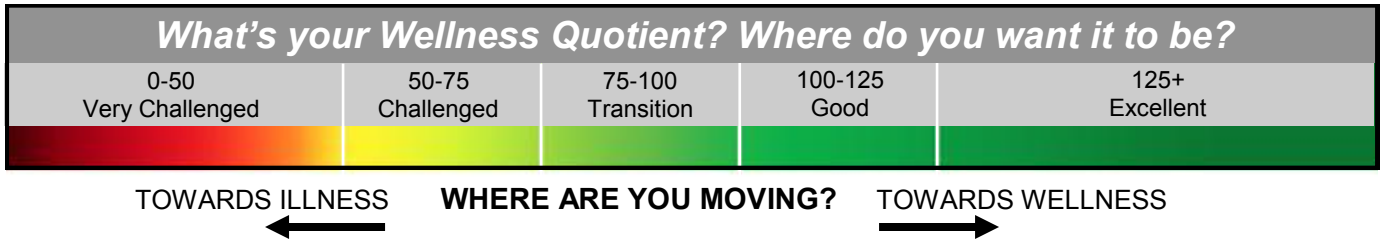
❑ **I want the doctor to select the type of care appropriate for my condition.**

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.*

❑ SLEEPING PROBLEMS	❑ DIZZINESS	❑ INFERTILITY	❑ FATIGUE	**FOR WOMEN ONLY:**
❑ NUMBNESS/TINGLING	❑ DEPRESSION	❑ ANXIETY	❑ ALLERGIES	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ LOW BACK PAIN	❑ NECK PAIN	❑ MID BACK PAIN	❑ HEADACHES	IF YES, WHEN IS YOUR DUE DATE?
❑ DIGESTIVE PROBLEMS	❑ ULCERS/COLITIS	❑ IRRITABILITY	❑ DIABETES	ARE YOU NURSING? ❑ YES ❑ NO
❑ BREATHING PROBLEMS	❑ COLD HANDS/FEET	❑ HOT FLASHES	❑ ASTHMA	ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
❑ SINUS PROBLEMS	❑ ARTHRITIS	❑ HEARTBURN	❑ CONSTIPATION	*DO YOU*: EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO
❑ MENSTRUAL PAIN/ IRREGULARITY	❑ HIGH BLOOD PRESSURE	❑ OTHER _____	❑ OTHER _____	HAVE IRREGULAR CYCLES? ❑ YES ❑ NO

Your Wellness Quotient is a number on a scale from 0-200 and is based on your current lifestyle choices-how and what you are eating, your sleep and exercise habits, etc. **INSTRUCTIONS:** *On the chart below, mark an "x" where you think your current Wellness Quotient is and mark an "O" where you want to be.*



The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

SIGNATURE: DATE:

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and associates of Advanced Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

SIGNATURE: DATE:

Advanced Chiropractic, P.A.
2485 Maplewood Drive Suite 215 Maplewood, MN 55109
651-770-7938 www.advancedchiromn.com

Terms of Acceptance

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during 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 a health care provider who specializes in that area. 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 main practice objective is to eliminate and correct the presence of vertebral subluxations and their interference to the body using specific adjustments.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

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

Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below whom I am legally responsible) by the licensed doctors of chiropractic of Advanced Chiropractic, P.A. or any doctor, who now or in the future, works as a relief doctor.

I authorize payment of insurance benefits directly to Advanced Chiropractic, P.A. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Advanced Chiropractic, P.A. to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I understand that if any payments from my insurance company are sent to me for services rendered at Advanced Chiropractic, P.A, that I am responsible for getting said payments applied to my account and any outstanding charge. I realize that my insurance benefits are a contract/agreement between myself and my insurance company, and Advanced Chiropractic, P.A. is not responsible for quoting medical benefits. Any benefits quoted are just an estimation. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

_____ _____

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 fully understand the Terms of Acceptance and Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have also read and understand the Notice of Privacy Practices and that 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 therefore accept chiropractic care on this basis.

_____ _____

Patient Name *(Please Print)* Relationship to Patient *(If Patient is a Minor)*

_____ _____

Signature Date

Advanced Chiropractic, P.A.
2485 Maplewood Drive Suite 215 Maplewood, MN 55109
651-770-7938 www.advancedchiromn.com