

Adult Member Health Record

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	
AGE:	
MARITAL STATUS:	GENDER:
NUMBER OF CHILDREN & AGES:	
EMPLOYER NAME:	
WORK PHONE:	POSITION TITLE:
LAST 4 OF SOCIAL SECURITY:	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES # PACK/DAY <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES # DRINKS/MONTH <input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA? <input type="checkbox"/> YES # CUPS/DAY <input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES # DAYS/WEEK <input type="checkbox"/> NO
DO YOU EAT FAST FOOD? <input type="checkbox"/> YES # OF MEALS/WEEK _____ <input type="checkbox"/> NO
ARE YOU AWARE OF THE EFFECTS OF YOUR DIET ON YOUR OVERALL HEALTH? <input type="checkbox"/> YES <input type="checkbox"/> NO
WOULD YOU LIKE MORE INFORMATION ON THE EFFECTS OF DIET ON YOUR HEALTH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU SLEEP WELL? <input type="checkbox"/> YES <input type="checkbox"/> NO # OF HOURS/DAY _____
HOW DO YOU SLEEP? <input type="checkbox"/> BACK <input type="checkbox"/> SIDE <input type="checkbox"/> STOMACH
DO YOU WEAR:
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS

CHIROPRACTIC HISTORY

WHO May We Thank For Your Referral?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> SOCIAL MEDIA <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN CHECKED FOR VERTEBRAL SUBLUXATION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> I DON'T KNOW
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 YOUR LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

REASON FOR THIS VISIT: <input type="checkbox"/> WELLNESS <input type="checkbox"/> PAIN COMPLAINT <input type="checkbox"/> AUTO/JOB INJURY <input type="checkbox"/> NUTRITION
PLEASE DESCRIBE:
WHAT DATE DID THIS BEGIN?
DID THIS PROBLEM START: <input type="checkbox"/> SUDDENLY <input type="checkbox"/> GRADUALLY <input type="checkbox"/> AFTER AN INJURY
HAS THIS CONCERN: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> BECOME CONSTANT/CHRONIC <input type="checkbox"/> GOTTEN BETTER <input type="checkbox"/> COME AND GONE
WHAT MAKES THE PROBLEM BETTER?
WHAT MAKES THE PROBLEM WORSE?
DOES THIS CONCERN INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
PLEASE DESCRIBE THE QUALITY OF THE PAIN (SHARP, DULLY ACHY, ETC.)
DOES THE PAIN RADIATE? <input type="checkbox"/> YES <input type="checkbox"/> NO TO WHERE?
RATE THE SEVERITY OF THE PAIN (0=NO PAIN, 10=E.R. VISIT):
DOES THE PAIN CHANGE THROUGHOUT THE DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS COMPLAINT? <input type="checkbox"/> YES <input type="checkbox"/> NO DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT NOT ALL CHIROPRACTIC CARE IS THE SAME AND NOT EVERY CHIROPRACTIC APPROACH IS SPECIFIC?

YES NO

ARE YOU AWARE THAT CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?

YES NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?

YES NO

ARE YOU AWARE THAT SYMPTOMS OFTEN TIMES ARE THE LAST TO SHOW UP?

YES NO

DID YOU KNOW THAT YOU CAN HAVE LOSS OF FUNCTION WITHOUT EXPERIENCING PAIN?

YES NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?

YES NO

DID YOU KNOW THAT CHIROPRACTIC CARE CAN HELP CHILDREN FUNCTION OPTIMALLY TOO?

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. PLEASE PICK ONE.

- As Needed:** Symptomatic relief of pain or discomfort.
- Corrective Care:** Correcting and relieving the cause of the problem as well as the symptom or pain.
- Maintenance/ Wellness:** Prevent future problems from occurring and old ones from returning.
- I want the Doctor to select the type of care for my condition.*

PERSONAL HISTORY

DO YOU HAVE ANY DIAGNOSED DISEASES (HEART DISEASE, DIABETES, ETC.)? YES NO
PLEASE LIST:

DO YOU HAVE A HISTORY OF CAR ACCIDENTS, BROKEN BONES, FALLS OR OTHER TRAUMAS? YES NO
PLEASE LIST:

HAVE YOU HAD ANY SURGERIES? YES NO
PLEASE LIST WITH APPROXIMATE DATES:

ARE YOU CURRENTLY EXPERIENCING ANY MAJOR STRESS IN YOUR LIFE OTHERWISE UNLISTED ON THIS FORM? YES NO

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please **CIRCLE** below 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'.

OTHER SYMPTOMS

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



Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

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

OTHER:

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE _____
 M F S G

DEPRESSION
 M F S G

DIABETES
 M F S G

HEART DISEASE
 M F S G

LIVER DISEASE
 M F S G

HIGH CHOLESTEROL
 M F S G

HIGH BLOOD PRESSURE
 M F S G

LUNG PROBLEMS
 M F S G

SEIZURES
 M F S G

NECK PROBLEMS
 M F S G

BACK PROBLEMS
 M F S G

SCOLIOSIS
 M F S G

OSTEOARTHRITIS
 M F S G

RHEUMATOID ARTHRITIS
 M F S G

AUTOIMMUNE DISEASES
 M F S G

OTHER: _____

SERVING THE WHOLE BODY, AND THE WHOLE FAMILY!

CURRENT MEDICATIONS

When properly prescribed, medications mask the symptoms of disease & contribute to more than 100,000 deaths annually. Please list the medications you take and your dosage:

Please list any supplements you are currently taking:

FEMALE PATIENTS

ARE YOU: CYCLING MONTHLY PERIMENOPAUSAL MENOPAUSAL

ARE YOU CURRENTLY PREGNANT? YES NO

IF YES, HOW FAR ALONG? _____ WEEKS

DUE DATE: _____

ARE YOU CURRENTLY BREASTFEEDING? YES NO

ARE YOU CURRENTLY USING BIRTH CONTROL? YES NO

WHAT TYPE?

DO YOU:

EXPERIENE PAINFUL PERIODS? YES NO

HAVE IRREGULAR CYCLES? YES NO

HAVE HEAVY/CLOTTY PERIODS? YES NO

HAVE SPOTTING BETWEEN CYCLES? YES NO

HAVE PAINFUL OR CRAMPY PERIDS? YES NO

EXPERIENCE INFERTILY? YES NO

PERFORM MONTHLY BREAST EXAMS? YES NO

HAVE ANNUAL MAMMOGRAMS? YES NO

YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS?

1. _____

2. _____

3. _____

IF THERE ARE ANY ISSUES THAT YOU ARE EXPERIENCING, OR THAT YOU HAVE CONCERNS ABOUT THAT HAVE NOT BEEN ADDRESSED ON THESE FORMS, PLEASE WRITE THEM IN USING THE SPACE BELOW.

THANK YOU FOR CHOOSING VERITY HEALTH CENTER AND HELPING US CONTINUE OUR MISSION TO
Help Families Experience True Health!

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

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 risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at **Verity Health Center**, 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.

_____/_____/_____
Patient or Authorized person's Signature Date _____ *Witness Initials*

REGARDING X-RAYS/ IMAGING STUDIES

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.

Signature: _____ Date: _____

Witness: _____ Doctor Signature: _____ Date: _____

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 receptionist 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.

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 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. I also allow use of my personal email address for office communication.

To receive text appointment reminders, initial here _____

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE: