PATIENT HEALTH RECORD

Name of Patient_____ Date_____

Welcome to Premier Chiropractic.

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific chiropractic care.

PREMIER CHIROPRACTIC

ABOUT THE PATIENT

Name_____ **Date**_____
Address_____
City_____ **State**_____ **Zip**_____
Home Phone_____
Cell Phone _____
Birth date_____ **Age**_____
Gender ☐ M ☐ F
Marital Status ☐Married ☐Single
☐ Divorced ☐ Separated ☐Widowed
Number of Children_____
Occupation _____
Employer_____
Work Address_____
City_____ **State**_____ **Zip** _____
Work Phone_____
Type of Work_____
Social Security #_____-_____-_____
Driver's License #_____
E-Mail Address_____
Insurance Provider Name _____

ABOUT THE SPOUSE

Name_____

Employer_____

Employer Address_____

Work Phone_____

Type of Work_____

GOALS FOR MY 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 bodies. Your Doctor will weigh your needs and desires when recommending your treatment 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 symptoms
- ☐ **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

AWARENESS OF CHIROPRACTIC PRINCIPLES

Where you aware that:

1. **Doctors of chiropractic work with the nervous system?** ☐ Yes ☐ No
2. **The nervous system controls all bodily functions and systems?** ☐ Yes ☐ No
3. **Chiropractic is the largest natural healing profession in the world?** ☐ Yes ☐ No
4. **If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?** ☐ Yes ☐ No

EXPERIENCE WITH CHIROPRACTIC

Have you been adjusted by a chiropractor before? _____

Reason for those visits? _____

Doctor's Name_____

Approximate date of last visit_____

Have you had x-rays of your spine taken in the last 5 years ☐Yes ☐ No

Has any *adult* in your family seen a chiropractor?
☐ Yes ☐ No

Has any *child* in your family seen a chiropractor?
☐ Yes ☐ No

IN EMERGENCY, CONTACT:

Name_____

Relationship_____

Work Phone_____

Home Phone_____

Cell Phone_____

Current Health Condition

MEDICATIONS I NOW TAKE

- ☐ Nerve Pills
- ☐ Blood Thinners
- ☐ Insulin
- ☐ Pain Killers (including Aspirin)
- ☐ Blood Pressure Medicine
- ☐ _____
- ☐ Stimulants
- ☐ Muscle Relaxers
- ☐ Tranquilizers
- ☐ _____
- ☐ _____

HEALTH HABITS

	YES	NO
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you drink coffee?	☐	☐
Do you exercise regularly?	☐	☐
Do you drink water?	☐	☐

Do you wear ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch Supports

HEALTH CONDITIONS

Please check any of the diseases or conditions that the patient has now or has 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.

- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bursitis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Concussion
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Digestive Problems
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Foot Pain
- ☐ Frequent Neck Pain
- ☐ Gout
- ☐ Hand Pain
- ☐ Heart Attack/Stroke
- ☐ Heart Murmur
- ☐ Heart Surgery/Pacemaker
- ☐ Hepatitis A/B/C
- ☐ High/Low Blood Pressure
- ☐ Hip Pain
- ☐ HIV\ AIDS
- ☐ Kidney Problems
- ☐ Loss of Sleep
- ☐ Lower Back Problems
- ☐ Multiple Sclerosis
- ☐ Muscle Spasms
- ☐ Nervousness
- ☐ Numbness or Pain in Arms/Hands
- ☐ Numbness or Pain in Legs/Feet
- ☐ Pain Between Shoulders
- ☐ Psoriasis
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Severe or Frequent Headache
- ☐ Shingles
- ☐ Shoulder Pain
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Ulcers/Colitis
- ☐ Venereal Disease

FOR WOMEN:	YES	NO
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control?	☐	☐
Do you experience painful periods?	☐	☐
Do you have irregular cycles?	☐	☐
Do you have breast implants?	☐	☐

Reason for this visit

Is the purpose of this appointment related to: ☐ Job ☐ Sports ☐ Auto ☐ Fall ☐ Home Injury
☐ Chronic Discomfort ☐ Other please explain_____
If job related, have you made a report of your accident to your employer? ☐ Yes ☐ No
When did this condition begin? _____
Has this condition: ☐ Gotten Worse ☐ Stayed Constant ☐ Comes and Goes
Does this condition interfere with: Work Sleep Daily Routine Other Activities: Explain_____
Has this condition occurred before? Yes No Explain_____
Are you, or have you seen other doctors for this condition? Yes No Dr'Name_____
Type of Treatment_____ Results_____

Who should receive bills for payment on your account?

☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Personal Health Insurance

Consent to X-Ray's and Ownership of X-Ray films.

Patient consent to X-Ray
I authorize the performance of diagnostic x-ray examination of myself which my treating doctor and\or Premier Chiropractic may consider necessary of advisable in the course of my examination and treatment.

Signed_____ Date_____

Consent to X-Ray a Minor
I am the parent or legal representative of _____, who is a minor, _____years of age. I authorize the performance of diagnostic x-ray examination of this child or ward which his\her treating doctor and/or Premier Chiropractic may consider necessary of advisable in the course of my examination and treatment

Signed_____ Date_____

Females: Regarding possibility of pregnancy
This is to certify that, to the best of my knowledge, I am not pregnant and Premier Chiropractic has my permission to perform a diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed_____ Date_____

Females: Consent to X-Ray during Pregnancy
This is to certify that I am or may be pregnant and that Premier Chiropractic has my permission to perform a diagnostic x-ray examination involving my cervical spine (neck) or extremities (arms, legs), on the condition the lead shielding be utilized over the trunk of my body. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed_____ Date_____

It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain in the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

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 beliefs (if applicable) directly to the provider for services rendered.

I consent to the use or disclosure of my protected health information by Premier Chiropractic for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Premier Chiropractic.

_____ _____
Patient's Signature **Date**

_____ _____
Guardian Spouse's Signature Authorizing Care **Date**