TotalFamily CHIROPRACTIC

ADULT HEALTH RECORD

ABOUT YOU

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

❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

PLEASE LIST YOUR CHILDREN'S NAMES &AGES

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

EMPLOYER NAME:	
WORK PHONE:	OCCUPATION:

PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

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? ❑ YES ❑ NO
HOW MANY HOURS PER NIGHT? _____

DO YOU TAKE A DAILY VITAMIN OR SUPPLEMENT? ❑ YES ❑ NO

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:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

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 PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? ❑ YES ❑ NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

Total Family Chiropractic
15226 West Freeway Drive Forest Lake, MN 55025
ph: 651-653-2190 | fax: 651-464-7793

ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ❑ YES ❑ NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ❑ YES ❑ NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

MEDICATIONS YOU TAKE

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

- ❑ **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.**

Would you like to know more about:

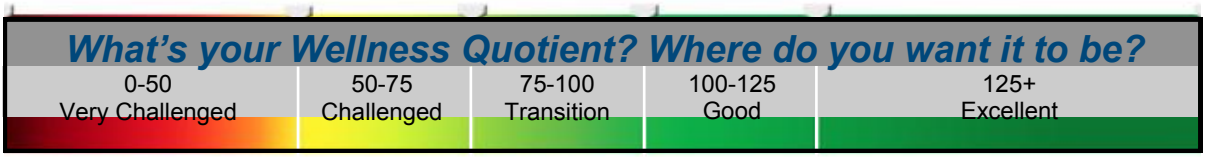
- ❑ Proper nutrition, meal planning, vitamins and supplements
- ❑ Proper exercise routines and techniques
- ❑ How to deal with lifestyle stress

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*:
❑ MENSTRUAL PAIN/ IRREGULARITY	❑ HIGH BLOOD PRESSURE	❑ OTHER _____	❑ OTHER _____	EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO 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.*



TOWARDS ILLNESS **WHERE ARE YOU MOVING?** TOWARDS WELLNESS

Please list below any surgeries, major illnesses, or accidents of your past. Please include dates.

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.

Print Name _____ Signature _____ Date _____

Total Family Chiropractic
15226 West Freeway Drive Forest Lake, MN 55025
ph: 651-653-2190 | fax: 651-464-7793

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

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.

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 ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

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.

_____ _____

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

_____ _____

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 Total Family 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

Total Family Chiropractic
15226 West Freeway Drive Forest Lake, MN 55025
ph: 651-653-2190 | fax: 651-464-7793