Applied Health ASSOCIATES

Date _____

ADULT HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE: _____

RELATIONSHIP: _____

DO YOU PREFER APPOINTMENT REMINDERS BY:

❑ EMAIL ❑ TEXT (Information is for office use only)

DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	GENDER:
MARITIAL STATUS:	NUMBER OF CHILDREN:

EMPLOYER NAME: ☐ Retired	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	OCCUPATION:

ABOUT YOUR SPOUSE

SPOUSE NAME:	
SPOUSE EMPLOYER:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
OCCUPATION:	

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HOW DID YOU HEAR ABOUT OUR OFFICE (CHECK ALL THAT APPLY):
❑ INSURNACE WEBSITE ❑SIGN/DRIVE BY ❑ YELLOW PAGES
❑COMMUNITY EVENT ❑FACEBOOK ❑YELP ❑GOOGLE
❑AHA WEBSITE ❑MAGAZINE ❑I SEE YOUR PENS/SHIRTS EVERYWHERE!

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 ANYONE IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

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.

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

WERE 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

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REASON FOR THIS VISIT

DESCRIBE THE PROBLEM OR CONDITION THAT IS CAUSING YOU TO SEEK CARE:

WHEN DID THIS CONDITION BEGIN?

HOW WOULD YOU CLASSIFY THIS CONDITION?:
❑ MINOR ❑ CHRONIC ❑ SERIOUS ❑ SEVERE

HAVE YOU EVER HAD THIS SAME OR SIMILAR PROBLEM? ❑ YES ❑ NO

IF YES PLEASE EXPLAIN:

SELECT ANY OF THESE THAT DESCRIBE YOUR PAIN:

❑ SHARP ❑ STABBING ❑ BURNING ❑ DULL ❑ SORE ❑ WEAK ❑ THROBBING ❑ NUMB ❑ SHOOTING ❑ GRIPPING ❑ TINGLING
❑ CRAMPING ❑ PINS & NEEDLES/PRICKLY ❑ OTHER - PLEASE EXPLAIN:

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

PLEASE EXPLAIN:

SINCE THIS PROBLEM BEGAN, IS THE PAIN: ❑ INCREASING ❑ DECREASING ❑ NOT CHANGING

DID THIS PROBLEM BEGIN: ❑ IMMEDIATELY FOLLOWING A SPECIFIC INCIDENT ❑ WITH MULTIPLE INCIDENTS ❑ GRADUALLY OVER TIME

HAVE YOU SOUGHT OTHER TREATMENT FOR THIS CONDITION? ❑ YES ❑ NO

DOCTOR'S/THERAPIST'S NAME:

TYPE OF TREATMENT:

RESULTS:

HEALTH CONDITIONS

INSTRUCTIONS: *Please check each of the issues 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.*

❑ DIABETES	❑ BROKEN BONES	❑ SWELLING	❑ NOSE	**FOR WOMEN ONLY:**
❑ ARTHRITIS	❑ STROKE	❑ BLOOD PRESSURE	❑ THROAT	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ ULCER	❑ BRAIN/SPINAL CORD	❑ APPETITE	❑ CHEST	IF YES, WHEN IS YOUR DUE DATE?
❑ KIDNEY	❑ CANCER	❑ DERMATITIS	❑ FACE	ARE YOU NURSING? ❑ YES ❑ NO
❑ BLADDER	❑ BLURRY VISION	❑ URINATION	❑ PARALYSIS	ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
❑ HEART	❑ EARS RINGING	❑ DEFECATION	❑ DIZZINESS	DO YOU:
❑ LUNGS	❑ CONFUSION	❑ SEXUAL ORGANS	❑ FAINTING	EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO
❑ STOMACH	❑ ALLERGIES	❑ HEADACHES	❑ SURGERIES:	HAVE IRREGULAR CYCLES? ❑ YES ❑ NO
❑ LIVER	❑ CONVULSIONS	❑ DEPRESSION		HAVE BREAST IMPLANTS? ❑ YES ❑ NO
❑ BOWEL	❑ EMOTIONAL	❑ SLEEP DISTURBANCE		OTHER HISTORY? ❑ YES ❑ NO IF YES, PLEASE EXPLAIN:

HEALTH HABITS

DO YOU SMOKE?	❑ YES	❑ NO
DO YOU DRINK ALCOHOL?	❑ YES	❑ NO
DO YOU DRINK COFFEE, TEA OR SODA?	❑ YES	❑ NO
DO YOU EXERCISE REGULARLY?	❑ YES	❑ NO

DO YOU WEAR:
❑ HEAL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

SUBJECTIVE ASSESSMENT

Please use the following symbols to accurately mark the areas on the image below in which you feel any of the described sensations. Include all affected areas.

Dull Pain: N N N Stabbing/Cutting Pain: /// /// /// Burning: X X X

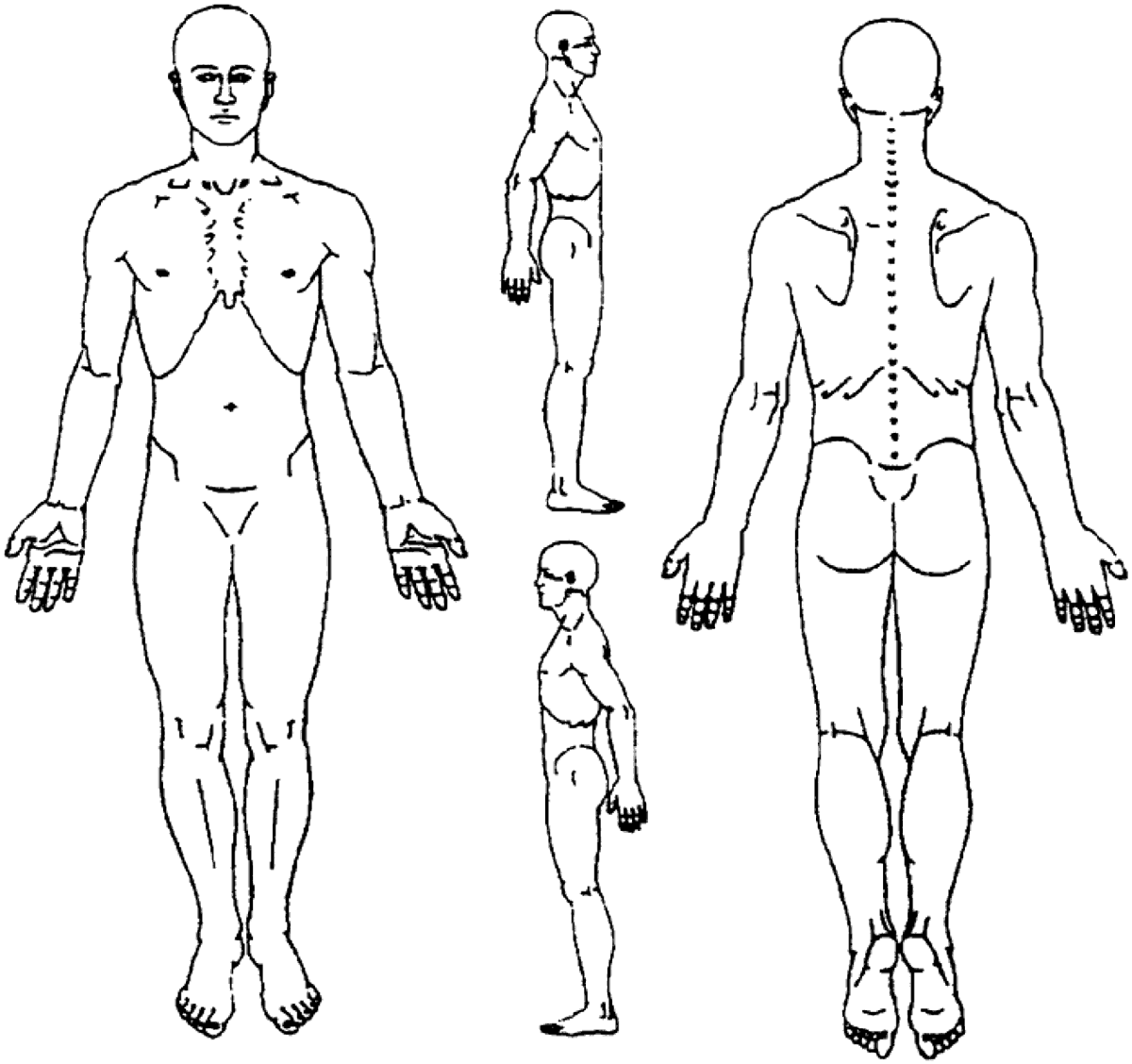
Numbness: = = = Tingling (pins & needles): :::::: Cramping: S S S

MEDICATIONS YOU TAKE

❑ACETAMINOPHEN	❑ INSULIN
❑ ANTIBIOTICS	❑ STEROIDS
❑ ANTIHISTAMINES	❑ PAIN KILLERS
❑ ASPIRIN	❑ RECREATIONAL DRUGS
❑ BLOOD THINNERS	❑ THYROID MEDICATION
❑ BLOOD PRESSURE MEDICATION	❑ TRANQUILIZERS
❑ COLD REMEDIES	❑ BIRTH CONTROL
❑ HEART MEDICATION	❑ ANTI-INFLAMMATORIES

❑ OTHERS & WHY:

❑ VITAMINS & SUPPLEMENTS:



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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 benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

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 toward the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that we 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.

SIGNATURE:	DATE:
WITNESS 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.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

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PRACTICE MEMBER GUIDELINES

As your chiropractor, my main objective is to offer chiropractic and wellness services that will allow you to respond as quickly as possible, in the least amount of time and in the most cost-effective fashion. We will do everything in our power to see that this goal is reached. However, we cannot do it alone, we need your help.

As a practice member of Applied Healthcare Associates you have certain responsibilities to ensure you are working toward our mutual goal of "wellness".

Your Job…

1. Keep your appointment times, as scheduled.
2. Allow for ample time to care for your condition. (Time is a very important part of regaining your lost health.)
3. Participate in your health with exercises and healthy suggestions made by the doctor, create a healing environment for yourself.

In Addition…

1. Please consult us before you seek any other health or at-home treatments during spinal correction. Other care, treatments, or drugs may alter your progress and ultimate recovery.
2. It is our mission to see that every member of your family achieves and lives optimal health. To do this, they must be free of subluxations. We welcome any friend or family members to be present at your exam or future visits! We would also happy to send chiropractic information to a friend or relative whom you believe could benefit from chiropractic care.

Our office is designed and dedicated to fulfill your whole health needs. If you have any questions about any aspect of your care or our services, please feel free to discuss them with your doctor. Your health care is our top priority!

In order to provide the chiropractic care you need as conveniently and rapidly as possible, we have established special hours in which you can receive your adjustments with the absolute minimum of waiting. We call these ***Patient Preferred Adjusting Hours***. In order to make this possible, the following has been established.

- ❑ **Consultations:** If a consultation (i.e., questions that may need more time than a regularly scheduled adjustment) is needed with the doctor, it is requested that it should be scheduled during ***Expanded Exam Hours*** rather than during *Patient Preferred Adjusting Hours*. This will give you and the doctor the time necessary to solve any problems and answer any questions.

- ❑ **Examinations:** Examination, consultation, and report visits may require special time. To ensure you get the proper time and attention, these visits may need to be scheduled during our **Expanded Exam Hours**.

- ❑ ***Initals:_____ Missed Appointments:*** **Changes in appointments require a 24-hour advance notice.** ***There will be a $25.00 fee charged for all missed chiropractic appointments, and $35.00 for all missed massage appointments.*** **It is also very important to follow your treatment plan to get and stay well!**

- ❑ **New Injury or Accident:** If you are in an auto or work accident, experience a new injury, re-injury or exacerbation on an existing condition, please let us know when making your appointment so appropriate time is scheduled for the examination and care of the new injury.

- ❑ **Initials:_____ Payment:** It is our office policy that payment is made at the time of service. If you have insurance to support your care, your co-pay is due at the time of service. We will gladly submit each claim to your insurance and ask that any changes in your insurance are reported in a timely manner. If you have a percentage plan or a deductible to fulfill, we appreciate payment of the estimated charges at the time of your visit in order to reduce statements and keep billing costs down. Any amount not paid by your insurance company will be the responsibility of the patient. Any returned checks for NSF are charged a $25.00 fee. Any service denied by your insurance is your responsibility.

I have read and understand all patient requirements.	
SIGNATURE:	DATE:

Thank you for the opportunity to serve you!

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