ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
CELL PHONE:	CELL PHONE CARRIER:
EMAIL ADDRESS: WOULD YOU LIKE TO RECEIVE OFFICE UPDATES BY EMAIL? Y or N WOULD YOU LIKE TO RECIEVE APPT TEXT REMINDERS? Y or N	
DATE OF BIRTH:	GENDER:
LANGUAGE:	INSURANCE CARRIER: (Provide Card)
MARRIAGE STATUS:	CHILDREN:
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:

EMERGENCY CONTACT

EMERGENCY CONTACT:
EMERGENCY CONTACT PHONE:
EMERGENCY CONTACT ADDRESS:

HEALTH HABITS

DO YOU SMOKE? ❑ YES ❑ NEVER ❑ FORMER If yes, how much per day_____

DO 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 (3x weekly)? ❑ YES ❑ NO

EATING HABITS (Check all that apply)
❑ HEALTHY, WELL BALANCED ❑ ORGANIC ❑ HORMONE FREE
❑ MIX OF HEALTHY AND PROCESSED FOODS
❑ MOSTLY PROCESSED, FEW WHOLE FOODS ❑ EAT OUT OFTEN
❑ DIETING

❑ FOOD ALLERGIES/ SENSITIVITES_____

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):
❑ WEBSITE ❑ SIGN ❑ SOCIAL MEDIA ❑ COMMUNITY EVENT ❑ REFERRAL

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES DATE OF LAST VISIT?_____ ❑ NO

WHAT ARE YOUR GOALS AT MIND, BODY & SPIRIT CHIROPRACTIC?
(CHECK ALL THAT APPLY)

_____CHIROPRACTIC CARE _____ MASSAGE THERAPY

_____ ACUPUNCTURE _____ FOOD ALLERGY TESTING

_____ NUTRITIONAL CONSULT _____CUSTOM FIT ORTHOTICS

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT :

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ JOB ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY
❑ CHRONIC DISCOMFORT ❑ OTHER

DATE THE COMPLAINT BEGAN: _____/_____/_____

*Is your visit today related to an accident or work injury? Y N
Additional paperwork and accident insurance will need to be billed for injury/accident claims. *Treatment for Work injuries need to be authorized by your employer to protect your rights*.

RATE PAIN ON SCALE OF 1 TO 10 (circle the appropriate number):
1 (no pain) 2 3 4 5 (moderate) 6 7 8 9 10 (extreme)

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 AND RESULTS:

HAVE YOU HAD ANY SPECIAL TESTS FOR THIS CONDITION, X-RAY, MRI, EKG, BLOOD WORK, ETC?

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 HELPS NATURALLY TURN BREECH BABIES, HELPS CHILDREN AND BABIES SLEEP BETTER, BE CALM, IMPROVES DIGESTION, CONCENTRATION, DEVELOP HEALTHY POSTURE , AND PREVENT INJURY?
❑ 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.

❑ **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***

MEDICATIONS YOU TAKE

❑ CHOLESTEROL MEDS	❑ BLOOD PRESSURE MEDS
❑ ADHD MEDS	❑ BLOOD THINNERS
❑ DEPRESSION OR ANXIETY MEDS	❑ PAIN KILLERS
❑ HEARTBURN OR REFLUX MEDS	❑ HYPOTHYROID MEDS
❑ INSULIN OR DIABETIC	❑ OTHER:

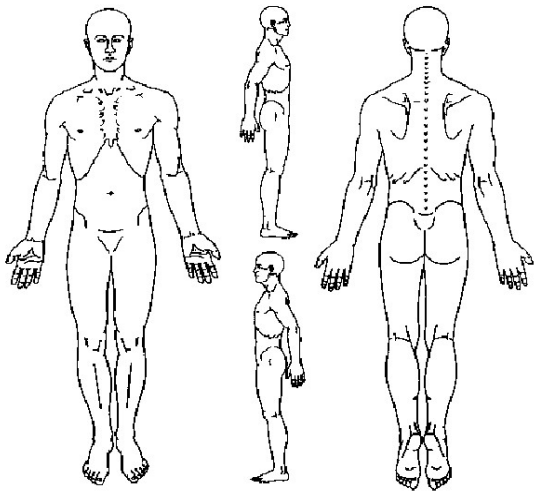
❑ VITAMINS, SUPPLEMENTS & HERBALS:

LIST ALLERGIES TO MEDS:_____

❑ **NO KNOWN ALLERGIES TO MEDS**

YOUR CONCERNS

INTRUCTIONS: *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 O=Other_____ (explain)



COMPLAINT 1:_____

RATE PAIN ON SCALE OF 1 TO 10 (circle the appropriate number):

1 (no pain) 2 3 4 5 (moderate) 6 7 8 9 10 (extreme)

FREQUENCY OF THE PAIN THROUGHOUT THE DAY

❑ **0-25%** ❑ **25-50%** ❑ **51-75%** ❑ **76-100%** **OTHER**_____

COMPLAINT 2:_____

RATE PAIN ON SCALE OF 1 TO 10 (circle the appropriate number):

1 (no pain) 2 3 4 5 (moderate) 6 7 8 9 10 (extreme)

FREQUENCY OF THE PAIN THROUGHOUT THE DAY

❑ **0-25%** ❑ **25-50%** ❑ **51-75%** ❑ **76-100%** **OTHER**_____

COMPLAINT 3:_____

RATE PAIN ON SCALE OF 1 TO 10 (circle the appropriate number):

1 (no pain) 2 3 4 5 (moderate) 6 7 8 9 10 (extreme)

FREQUENCY OF THE PAIN THROUGHOUT THE DAY

❑ **0-25%** ❑ **25-50%** ❑ **51-75%** ❑ **76-100%** **OTHER**_____

HEALTH CONDITIONS

SURGERIES	FAMILY HISTORY M=Mother F=Father	TRAUMA	FOR WOMEN ONLY:
SURGERY: YEAR:	❑ HEART DISEASE M / F	❑ CAR ACCIDENT YEAR:	ARE YOU PREGNANT? ❑ YES, *DUE*: ❑ NO DIFFICULTY GETIING PREGNANT? ❑ YES ❑ NO
SURGERY: YEAR:	❑ STROKE M / F	❑ FALL YEAR:	REGULAR MAMMOGRAMS ❑ YES ❑ NO REGULAR BREAST EXAMS ❑ YES ❑ NO REGULAR PAP/PELVIC EXAMS ❑ YES ❑ NO
SURGERY: YEAR:	❑ CANCER M / F TYPE:_____	❑ SPORTS INJURY YEAR:	MENOPAUSE SYMPTOMS? ❑ YES ❑ NO EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO HAVE IRREGULAR CYCLES? ❑ YES ❑ NO
SURGERY: YEAR:	❑ AUTOIMMUNE M / F TYPE:_____	❑ _____ YEAR:	**ANY OTHER HEALTH CONCERN YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT?**
SURGERY: YEAR:	❑ _____ M / F	❑ _____ YEAR:	_____ _____ _____
SURGERY: YEAR:	❑ _____ M / F	❑ _____ YEAR:	

You are responsible for any balance not paid by your insurance company

IF NO INSURANCE: Payment is due when treatment is given. INSURANCE: Deductibles, co-payments, and non-covered services are expected to be paid at the time of service . It is your responsibility to provide us with the proper insurance card. If you discontinue treatment, any charges are immediately due and payable. TREATMENT PERMISSION: I understand that I am responsible for all charges whether or not paid by any third party. I agree that all charges are payable, collectible, and prosecutable in Linn County. A service fee of $5.00 per month will be charged on any balance over 60 days old. If I do not make payment on my account after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. All portions of any bill sent me by Mind, Body & Spirit Chiropractic PLC shall be assumed valid unless disputed in writing within thirty (30) days of receiving the bill. ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS: I authorize Mind, Body & Spirit Chiropractic, PLC to file my insurance claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Mind, Body & Spirit Chiropractic, PLC. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict, settlements or recoveries, and to adequately protect and to make payment for these services directly to Mind, Body & Spirit Chiroropactic, PLC pursuant to this assignment and lien. ASSIGNMENT OF CAUSE OF ACTION: If any insurance company or third party may be obligated to pay to me or to Mind, Body & Spirit Chiropractic, PLC for charges for services, refuses to make such payment upon demand, I assign, transfer, and convey to Mind, Body & Spirit Chiropractic, PLC the cause of action that may exist in my favor against such company or person. I authorize Mind, Body & Spirit Chiropractic, PLC to prosecute said action either in my name or their name to collect fees due for care rendered at Mind, Body & Spirit Chiropractic, PLC for legal expenses and to resolve said claims as they see fit. AUTHORIZATION TO PROCESS DRAFTS: I agree that Mind, Body & Spirit Chiropractic, PLC shall be appointed as my agent to endorse drafts or to sign my name on any checks for payment of my bill for chiropractic services rendered. LIMITED RELEASE OF MEDICAL INFORMATION: I authorize Mind, Body & Spirit Chiropractic, PLC to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments. NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the Notice of Privacy Practices.

PRINT NAME:_____SIGNATURE:_____Date:_____

Informed Consent to Chirorpractic Care

Nature and Purpose of Chiropractic Procedures: The practice of chiropractic includes many standard examination and testing procedures, including physical examination, orthopedic and neurological testing, palpation, specialized instruments, radiology exams, physical therapy and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession –the chiropractic adjustment. Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s). There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of quick precise movement over a very short distance to a specific segmental contact point of a vertebra. Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome (VAS), including stroke (rare: 1 in 3-5 million) and perhaps, death through complicating factors.

AUTHORIZATON FOR CHIROPRACTIC CARE: I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

SIGNATURE:	DATE:
CONSENT TO TREAT A MINOR SIGNATURE OF PARENT OR GUARDIAN:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

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

Please mark each item below for each sign or symptom you currently have or previously had:
Mark "C" for current Mark "P" for past Current = within the last 3 months

CONSTITUTIONAL
__ Weight Loss
__ Weight Gain
__ Decrease Energy
__ Increase Energy
__ Difficulty Sleeping

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Osteoporosis
__ Joint Replacement
__ Herniated Disc
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Muscle Weakness
__ Sprains/Strains
__ Broken Bones
__ Gout
__ Fibromyalgia
__ Arthritis

CARDIOVASCULAR
__ High Blood Pressure
__ Heart Attack
__ Chest Pain
__ Poor Circulation
__ Heart Disease
__ Irregular Heartbeat
__ Jaw pain
__ Aortic Aneurism
__ Swelling Ankles
__ Varicose Veins
__ High Cholesterol
__ Pacemaker/Defibrillator

EAR/EYE/NOSE/THROAT
__ Ear Noises
__ Dizziness
__ Sore Throat
__ Hearing Loss
__ Nasal Blockage
__ Nose Bleeds
__ Glaucoma
__ Sinusitis
__ Difficulty Swallowing
__ Bleeding Gums
__ Double Vision
__ Blurred Vision

GASTRO-INTESTINAL
__ Bowel Problems
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Gallbladder Problem
__ Nausea/ Vomiting
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Liver Problems
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Tuberculosis
__ Shortness of Breath
__ Emphysema
__ COPD
__ Cold/Flu
__ Cough/Wheezing

__ Covid 19 / Date:

Have your received your Covid 19

Vaccine? Y/N Date:_____

GENITOURINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Disease
__ Painful Urination
__ Kidney Stone
__ Loss of Bladder Control
__ STD

NEUROLOGIC
__ Stroke
__ Seizures
__ Head Injury
__ Brain Aneurysm
__ Numbness
__ Severe Headaches
__ Pinched Nerves
__ Parkinsons
__ Stiff Joints
__ Carpal Tunnel
__ Spinning/Balance
__ Multiple Sclerosis
__ Migraines

ALLERGIC/IMMUNOLOGIC
__ Hives
__ Immune Disorder
__ HIV/AIDS
__ Allergy Shots
__ Cortisone Use

INTEGUMENTARY
__ Skin Ulcers
__ Skin Disease
__ Eczema
__ Psoriasis
__ Rashes
__ Dryness
__ Sensitive Skin
__ Boils

HEMATOLOGIC/LYMPHATIC
__ Hepatitis
__ Blood Clots
__ Cancer
__ Easy Bruising
__ Easy Bleeding
__ Fevers/Chills/Sweats

PSYCHIATRIC
__ Depression
__ Anxiety Disorder
__ Unusual Stress
__ ADHD
__ Mental Disorder
__ Alcoholism
__ Drug Addiction

ENDOCRINE
__ Diabetes Type I or II
__Thyroid – Hyper or Hypo
__ Hair Loss
__ Excessive Thirst

WOMEN ONLY
__ Difficult Periods
__Hot Flashes
__ Irregular Cycles
__ Breast Pain
__ Lump In Breast
__ Difficulty Becoming Pregnant
__ Pregnancy Complications
__ Pain With Intercourse
__ Pelvic Pain
__ Cramps
__ Birth Control
__ Pregnant At This Time
__ Date Of Last Period Ended
__ Last Gynecologic Exam

MEN ONLY
__ Testicular Pain
__Prostate Problems
__ Difficult Erection
__ Low Sperm Count
__ Pain With Intercourse
__ Pelvic Pain

Have you had any recent: surgeries, trauma, Illness, recent diagnosis or new medications in the past year?

If yes, please explain _____

_____

Name:_____ Date:_____

BP:_____/_____ HR:_____

Height:_____ Weight:_____

mind, body & spirit chiropractic