Alternative Chiropractic Center, P.C.

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Confidential Patient Health Record

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

Email _____ Date of Birth _____ S.S.# _____

Martial Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Number of Children and Ages _____

Employer Name _____

Employer Address _____

How did you hear about us? _____

Whom may we thank for referring you? _____

Emergency Contact

Name _____ Relationship _____

Home Phone # _____ Work Phone _____

Patient Condition

Primary Reason for Care _____

Secondary Reason for Care _____

Date symptoms started _____

What are your main treatment goals? _____

How often do you experience the symptoms?

❑ Constant 100% ❑ Frequent 75% ❑ Intermittent 50% ❑ Occasional 25% ❑ Rare 10%

Are symptoms: ❑ Improving ❑ Progressively Worse ❑ Same

Describe any recent related accident or fall _____

What makes symptoms increase? _____

What makes symptoms decrease? _____

Type of pain:

❑ Sharp ❑ Dull ❑ Aching ❑ Burning

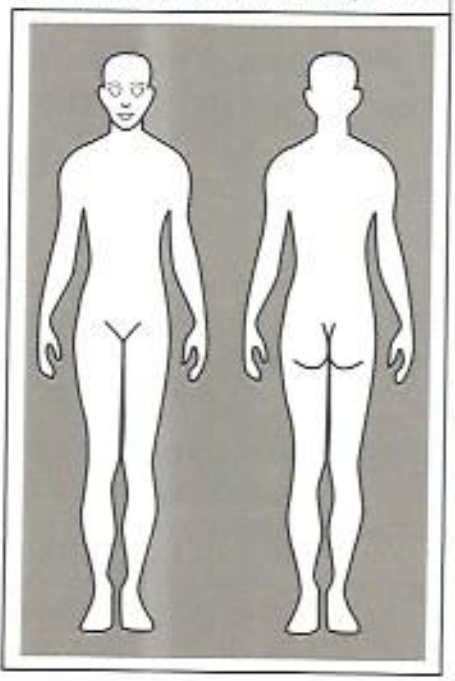
❑ Throb ❑ Numbness ❑ Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0----------5----------10

Please mark your areas of pain on the figure below



Health History

What treatment have you already received for your condition? ❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Acupuncture ❑ Chiropractic ❑ None ❑ Other _____

If so, Name and Address of doctor(s) who have treated you for your condition _____

_____

Please mark **C** if a current condition, **P** if a past condition and leave blank if not applicable.

___ ADD/ADHD
___ AIDS/HIV
___ Anemia
___ Anorexia
___ Anxiety
___ Appendicitis
___ Arm Pain
___ Arthritis
___ Asthma
___ Bronchitis
___ Bulimia
___ Cancer
___ Carpal Tunnel
___ Celiac Disease
___ Chest Pain
___ Chicken Pox
___ Chronic Fatigue
___ Cold Sores
___ Concussions
___ Cough
___ Crohn's Disease
___ Depression
___ Diabetes
___ Dizziness
___ Epilepsy
___ Fainting
___ Fibromyalgia
___ Gall Stones
___ Goiter
___ Gout
___ Headaches
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herniated Disc
___ Herpes
___ High Cholesterol
___ Hypertension
___ Irritable Bowel Disease
___ Infertility
___ Jaw pain
___ Kidney Infections
___ Kidney Stone
___ Knee Pain
___ Leg Pain
___ Liver Disease
___ Low Back Pain
___ Mid Back Pain
___ Migraine Headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Neck Pain
___ Night Sweats
___ Numbness or Tingling
___ Osteoporosis
___ Pacemaker
___ Parkinson's Disease
___ Pinched Nerve
___ Pneumonia
___ Polio
___ Prostrate Problems
___ Psychiatric Care
___ Rheumatic Fever
___ Scarlet Fever
___ Sciatica
___ Seizures
___ Shingles
___ Shoulder Pain
___ Sinus Congestion
___ STDs
___ Stroke
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumors/Growths
___ Ulcerative Colitis
___ Ulcers
___ Upper Back
___ Urinary Tract Infection
___ Vaginal Infection
___ Whooping Cough

Others not listed above _____

Allergies:

❑ Dust ❑ Mold ❑ Trees ❑ Weeds ❑ Grass
❑ Animal ❑ Perfume ❑ Smoke ❑ Foods (list on next page)
❑ Others _____

Descriptions & Dates on the following:

Hospitalizations/Surgeries you have had _____

_____

Recent Infections (Cold, Flu etc) _____

_____

Falls/Injuries _____

_____

Fracture/Dislocations _____

_____

Medications _____

_____

Vitamins/Supplements _____

_____

Please list family history of any diseases or conditions _____

_____

Social and Occupational History

Diet: Food Cravings: ❑ Sweets ❑ Salt ❑ Sour ❑ Bitter ❑ Spicy

❑ Alcohol (type/drinks per week _____

❑ Sugar (type/amount per day _____

❑ Caffeine (type/drinks per day _____

❑ Tobacco (type/amount per day _____

Typical Breakfast: _____

Mid morning snack: _____

Typical Lunch: _____

Afternoon snack: _____

Typical Dinner: _____

Typical Beverages: _____

Favorite Foods: _____

Food Allergies: ❑ No ❑ Yes (list please) _____

FEMALE ONLY: Total Length of cycle _____ Length of Menses _____ Menses: ❑ Heavy ❑ Moderate ❑ Light

PMS ❑ Mood Swings ❑ Cramping ❑ Breast Tenderness ❑ Pregnant ❑ Post Menopausal ❑

Gastrointestinal: ❑ Excess Hunger ❑ Poor appetite ❑ Nausea ❑ Hemorrhoids ❑ Diarrhea ❑ Constipation ❑ Heartburn ❑ Gas

❑ Bloating ❑ Strong Smell # of Bowel Movements/Day _____

Sleep: Hours per night _____ Quality: ❑ Poor ❑ Fair ❑ Good ❑ Trouble Falling Asleep ❑ Staying Asleep ❑ Insomnia

At what time do you wake up _____ How many times do you wake up? _____

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach ❑ All Night Urination: How many times? _____

Urination: ❑ Excess urination ❑ Frequent urination ❑ Painful urination

Job activities include: _____

Physical activity at work ❑ Sedentary ❑ Light manual labor ❑ Moderate manual labor ❑ Heavy manual labor

How long do you speak on the telephone each day _____ ❑ Traditional receiver ❑ Headset

Do any of your work activities aggravate your present main complaints? Please Describe: _____

Stress Level: ❑ Mild ❑ Medium ❑ Severe

Reason _____

How do you handle stress? ❑ Exercise ❑ Sleep ❑ Eat ❑ Other _____

Energy Level: 0 1 2 3 4 5 6 7 8 9 10 Time of Lows _____

Exercise: 1. Type _____ Frequency _____

2. Type _____ Frequency _____

3. Type _____ Frequency _____

Consent for Care, Financial Policy Agreement, and Privacy Practices Acknowledgement for Alternative Chiropractic Center

Consent for Care: I, the undersigned, in consideration of Alternative Chiropractic Center's services, agree to the following terms:

I hereby grant permission to Alternative Chiropractic Center and its clinicians to perform examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. Clinicians who treat me include, but are not limited to: medical doctors, acupuncturists, massage therapists, herbalists, nutritionists, physical therapists, rolfers, and/or chiropractors. My signature on this document serves as my consent for treatment.

Authorization to Release Information for Insurance clients: I authorize Alternative Chiropractic Center to release any information required to process a claim to any insurance company or attorney. I also authorize any insurance company or medical provider to release my medical records to Alternative Chiropractic Center for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of this document is as valid and effective as the original copy.

Personal Responsibility for my Charges: I understand that I remain personally responsible for my charges, and that at any time I can request a copy of my total charges from the office. I agree to pay the full amount of my charges to the office upon their demand. Any partial payments toward my charges shall not be acceptance of any installment payment plan, and shall not constitute a waiver of Alternative Chiropractic's right to receive payment in full upon demand. In the event that any payer denies payment or claim by an insurance company or second party, I agree that I am personally, fully, and immediately responsible for the portion of my charges denied or likely to be denied. In no event shall I hold Alternative Chiropractic Center liable in any of the above named instances.

HIPAA Notice of Privacy Practices: I understand I have access to the Notice of Privacy Practices and am able to review it and obtain a copy at my request.

Liability Agreement: I have read, understood and agree to the terms of this agreement.

_____ (Initial Please) Cancellation Policy: I agree to give 24 hours notice if I need to cancel an appointment. I understand that if I fail to give 24 hours notice on more than one occasion, I will be subject to a charge of 50% of the scheduled appointment fee on the second instance; 100% of the scheduled appointment fee for the third instance and beyond.

Patient Signature _____ Date: _____

Patient Name (print) _____

Name of Custodial Parent/Legal Guardian _____

Parent/Guardian Signature _____ Date: _____