Allen Chiropractic Wellness Center

PATIENT HEALTH RECORD

Account #

ABOUT YOU

NAME:	DATE OF BIRTH:
ADDRESS:	
CITY:	STATE/ZIP CODE:
PHONE 1: HOME / CELL / WORK	PHONE 2: HOME / CELL / WORK
BEST NUMBER TO REACH YOU? ___ HOME ___ CELL ___ WORK MAY WE LEAVE A MESSAGE? ________ TEXT REMINDER?_____	
EMAIL ADDRESS	
EMPLOYER NAME:	NUMBER: OCCUPATION:
SOCIAL SECURITY NUMBER:	GENDER:
MARITAL STATUS:	PAYMENT METHOD: ☐ CASH ☐ CHECK ☐ CREDIT CARD
SPOUSE NAME	BEST PHONE #
SPOUSES EMPLOYER:	NUMBER
PRIMARY DOCTOR	PHONE
LAST VISIT	LAST PHYSICAL

EMERGENCY CONTACT

NAME:	RELATIONSHIP:
BEST PHONE #	ALT. PHONE #

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (üALL THAT APPLY):
☐ NEWSPAPER ☐ SIGN ☐ FACEBOOK ☐ COMMUNITY EVENT ☐ MAILING

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?

HEALTH HABITS

DO YOU SMOKE? ☐ YES ☐ NO
How much per day_______ How many years? __________

ALCOHOL CONSUMPION: HOW MUCH __________ HOW OFTEN? ________

DO YOU DRINK COFFEE, TEA OR SODA? _____ How much per day_______

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

DO YOU WEAR:
☐ HEEL LIFTS ☐ SOLE LIFTS ☐ INNER SOLES ☐ ARCH SUPPORTS

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO AN ACCIDENT:
☐ JOB ☐ SPORTS ☐ AUTO ☐ FALL ☐ HOME INJURY
DATE_________ ☐ CHRONIC DISCOMFORT ☐ OTHER
PLEASE EXPLAIN:

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT?
☐ AUTO INS ☐ WORKER'S COMP ☐ OTHER

WHEN DID THE SYMPTOMS BEGIN?

RATE YOUR WORST PAIN ON A SCALE OF 1-10 ____ ON A GOOD DAY____

TYPE OF PAIN (mark all that apply): Sharp___ Dull ___ Throbbing ___ Aching ___
Shooting ___ Numb ___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Other__

IS IT : CONSTANT ____ INTERMITTENT ____

HAS THIS CONDITION:
☐ WORSENED ☐STAYED CONSTANT ☐COME AND GONE

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

ACTIVITIES THAT ARE PAINFUL TO PERFORM:
SITTING ___ STANDING ___ BENDING ___ WALKING ___ LYING ___ OTHE R ___

HAS THIS CONDITION OCCURRED BEFORE? ☐ YES ☐NO
PLEASE EXPLAIN:

WHO HAVE YOU SEEN FOR THIS CONDITION? DOCTOR'S NAME:
NAME: PHONE:
ADDRESS:

TYPE OF TESTS: MRI ___ X-RAY ___
TREATMENT: Meds ___ Surgery ___ Phys. Therapy ___ Chiropractic ___

RESULTS:
WHERE WAS IT DONE:

NAME ____

ALLERGIES

ENVIRONMENTAL / FOOD / MEDICATIONS

SURGERIES

MEDICATIONS / SUPPLEMENTS

YOUR CONCERNS

***INSTRUCTIONS: Place an** X by the concerns or conditions you may be experiencing **NOW.** Each area of concern relates to an area of the spine and nerve function.*

Headaches ___
Migraines ___
Dizziness ___
Sinus ___
Allergies ___
Fatigue ___
Head colds ___
Vision ___
Difficulty Concentrating ___
Hearing ___
Jaw ___

→ C1 C2 C3 C4

Sore throat ___
Stiff neck ___
Radiating arm pain ___
Hand / Finger ___
Numbness ___
Asthma ___
Allergies ___
Blood pressure ___
Heart conditions ___
Thyroid ___

→ C5 C6 C7 T1

Mid Back ___
Congestion ___
Breathing ___
Bronchitis ___
Pneumonia ___
Gallbladder ___
Stomach ___
Ulcers ___
Gastritis ___
Kidney ___

→ T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

Constipation ___
Colitis ___
Diarrhea ___
Gas pain ___
Irritable bowel ___
Bladder ___
Menstrual issues ___
Low back pain ___
Leg pain ___
Numbness in legs ___
Reproductive ___

→ L1 L2 L3 L4 L5 SACRAL

OTHER:

____
____
____
____
____
____
____
____
____

HEALTH HISTORY

INSTRUCTIONS: *Please check each that **you or your family members have or have had in the past**. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and care plan.*

❑ SEVERE OR FREQUENT HEADACHES	❑ THYROID PROBLEMS	❑ STROKE	❑ EPILEPSY
❑ HEART ATTACK / PACEMAKER	❑ DIZZINESS /TINNITIS	❑ URINARY PROBLEMS	❑ HIGH BLOOD PRESSURE
❑ CONGENITAL HEART DEFECT	❑ HEPATITIS	❑ RHEUMATIC FEVER	❑ DIABETES
❑ DIGESTIVE PROBLEMS	❑ DIFFICULTY BREATHING	❑ ULCERS/COLITIS	❑ ASTHMA / BRONCHITIS
❑ PAIN BETWEEN SHOULDERS	❑ KIDNEY PROBLEMS	❑ TUBERCULOSIS	❑ HIV / AIDS HEPATITIS
❑ LOWER BACK PROBLEMS	❑ ANXIETY	❑ ARTHRITIS	❑ SLEEP PROBLEMS
❑ FREQUENT NECK PAIN	❑ CANCER	❑ SHINGLES	❑ SINUS PROBLEMS

FOR WOMEN ONLY:

ARE YOU PREGNANT? DUE DATE?	☐ YES	☐ NO
ARE YOU NURSING?	☐ YES	☐ NO
ARE YOU TAKING BIRTH CONTROL?	☐ YES	☐ NO
HAVE HORMONE IMPLANTS?	☐ YES	☐ NO
EXPERIENCE PAINFUL PERIODS?	☐ YES	☐NO
HAVE IRREGULAR CYCLES?	☐ YES	☐NO
HAVE BREAST IMPLANTS?	☐ YES	☐NO

ALLEN CHIROPRACTIC WELLNESS CENTER
1018 S WESTWOOD BLVD STE 5, POPLAR BLUFF, MO 63901
573-778-0500 HIPAA FAX : 888-972-7541

NAME : ______________________________

DOB: ____________________

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition using recommended protocols as 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 at time of service. 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.

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

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:

NO SHOW FEE

Your health care is very important to us. ***We expect you to keep scheduled appointments.***

- *Late arrival may require your appointment to be rescheduled.*
- *Should you need to reschedule, however, please call our office 24 HOURS in advance to* ***avoid being charged our regular office fee.***
- *Please understand that someone else in pain may need that time. We appreciate your cooperation in this matter.*
- *We manage our schedule to keep you and others from waiting a long time.*

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