Adult Member Health Record

ABOUT YOU

NAME:

ADDRESS:

CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:

EMAIL ADDRESS:

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

EMPLOYER ADDRESS:

WORK PHONE:	POSITION TITLE:

How would you like appointment reminder: ☐ Email ☐Text —>Carrier_____________

ABOUT YOUR SPOUSE

SPOUSE NAME:

SPOUSE EMPLOYER:

POSITION TITLE:

YOUR CHILDHOOD

DID YOU HAVE ANY CHILDHOOD ILLNESSES? ☐ YES ☐ NO ☐ UNSURE

DID YOU HAVE ANY SERIOUS FALLS AS A CHILD ☐ YES ☐ NO ☐ UNSURE

DID YOU PLAY YOUTH SPORTS ☐ YES ☐ NO ☐ UNSURE

DID YOU TAKE / USE ANY DRUGS? ☐ YES ☐ NO ☐ UNSURE

DID YOU HAVE ANY SURGERY? ☐ YES ☐ NO ☐ UNSURE

HAVE YOU FALLEN/JUMPED FROM A HEIGHT OVER 3 FEET? ☐ YES ☐ NO ☐ UNSURE

WERE YOU INVOLVED IN ANY CAR ACCIDENTS AS A CHILD? ☐ YES ☐ NO ☐ UNSURE

WERE THERE ANY PROLONGED USE OF MEDICINE SUCH AS ANTIBIOTICS OR AN INHALER? ☐ YES ☐ NO ☐ UNSURE

DID YOU SUFFER FROM ANY OTHER TRAUMAS? ☐ YES ☐ NO ☐ UNSURE

WERE YOU VACCINATED? ☐ YES ☐ NO ☐ UNSURE

AS A CHILD, WERE YOU UNDER REGULAR CHIROPRACTIC CARE? ☐ YES ☐ NO ☐ UNSURE

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):
☐ NEWSPAPER ☐ SIGN ☐ YELLOW PAGES ☐ 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 MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. I F YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE:

☐ WELLNESS ☐ SPORTS ☐ AUTO ☐ FALL ☐ HOME INJURY
☐ JOB ☐ CHRONIC DISCOMFORT ☐ OTHER

PLEASE EXPLAIN:

WHEN DID THIS CONCERN BEGIN?

HAS THIS CONCERN:
☐ GOTTEN WORSE ☐ STAYED CONSTANT ☐ COME AND GONE

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

PLEASE EXPLAIN:

HAS THIS CONCERN OCCURRED BEFORE? ☐ YES ☐ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? ☐ YES ☐ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS: ☐ GOOD ☐ BAD ☐ INDIFFERENT

Downers Grove Total Health
3000 Woodcreek Dr. Suite 120
Downers Grove, IL 60515

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

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:

❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

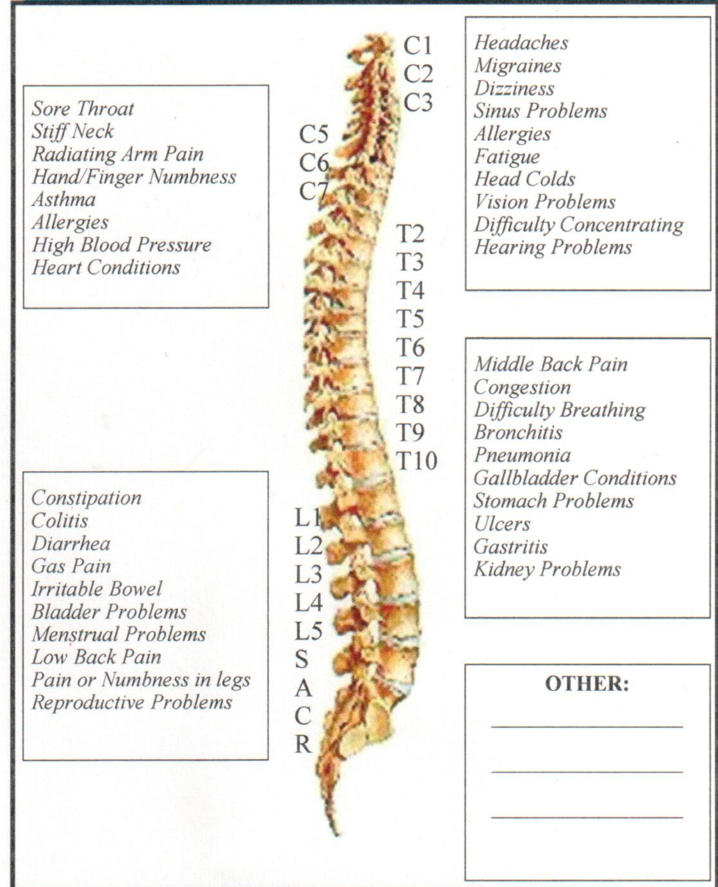
MEDICATIONS YOU TAKE

❑ CHOLESTEROL MEDICATIONS	❑ INSULIN
❑ STIMULANTS	❑ PAIN KILLERS
❑ TRANQUILIZERS	❑ BLOOD PRESSURE MEDICINE
❑ MUSCLE RELAXERS	❑ OTHER

SUPPLEMENTS YOU TAKE

❑ ESSENTIAL FATTY ACIDS	❑ PROBIOTIC
❑ MULTIVITAMIN WHICH :________________	❑ OTHER________________
❑ CALCIUM / MAGNESIUM	❑ OTHER ________________
❑ VITAMIN C	❑ OTHER ________________

YOUR CONCERNS



HEALTH CONDITIONS...

INSTRUCTIONS: *Please check each of the diseases or conditions that you now have or 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.*

				FOR WOMEN ONLY:
❑ SEVERE OR FREQUENT HEADACHES	❑ THYROID PROBLEMS	❑ PAIN IN ARMS/LEGS/ HANDS	❑ NUMBNESS	
❑ HEART SURGERY/ PACEMAKER	❑ SINUS PROBLEMS	❑ LOW BLOOD PRESSURE	❑ ALLERGIES	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ LOWER BACK PROBLEMS	❑ HEPATITIS	❑ RHEUMATIC FEVER	❑ DIABETES	IF YES, WHEN IS YOUR DUE DATE?
❑ DIGESTIVE PROBLEMS	❑ DIFFICULTY BREATHING	❑ ULCERS/COLITIS	❑ SURGERIES:	ARE YOU NURSING? ❑ YES ❑ NO
❑ PAIN BETWEEN SHOULDERS	❑ KIDNEY PROBLEMS	❑ TUBERCULOSIS	❑ ASTHMA	ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
❑ CONGENITAL HEART DEFECT	❑ HIGH BLOOD PRESSURE	❑ ARTHRITIS	❑ LOSS OF SLEEP	<u>DO YOU:</u> EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO HAVE IRREGULAR CYCLES? ❑ YES ❑ NO HAVE BREAST IMPLANTS? ❑ YES ❑ NO
❑ FREQUENT NECK PAIN	❑ CHEMOTHERAPY	❑ SHINGLES	❑ DIZZINESS	

SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

Informed Consent to Care

I hereby request and authorize the services of clinical procedures including chiropractic adjustments, various modes of physical therapy, neurological rehabilitation, diagnostic x-rays and other laboratory tests, on me or on patient named below, for whom I am legally responsible.

Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, reduce muscular soreness, and improve neurological function and overall well-being. It is important to understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures(broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

Potential side-effects of nutritional supplements administered for health improvement may include but are not limited to: upset stomach, bloating, gas, diarrhea, or mild headache, these are all transient and do not last. It is important to understand that there are options available for your condition other than chiropractic, rehabilitation, or nutritional means. These may include, but are not limited to: self-administered care, OTC pain relievers, rest, and medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

Ownership of X-ray films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative or data as kept on computer will remain the property of the office. They are kept on file where they may be accessed any time while you are a patient at this office. Lastly, the doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis, and you have the right to a second opinion about your circumstances and health care as you see fit.

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 form 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.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Patient Name: ______________________ Signature: _________________________________ Date: ______________

Parent/Guardian: __________________ Signature: __________________________________ Date: ______________

Witness Name: _____________________ Signature: __________________________________ Date: ______________

Insurance Assignment & Release

I certify that I, and/or my dependent(s), have Insurance coverage with ________________ (*Name of Insurance Company*) and assign directly to Dr. ________________all Insurance benefits, if any, otherwise payable to me for services rendered. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. I understand that I, personally, am financially responsible to Experience Chiropractic for charges not covered by the assignment of insurance benefits. We do our best to ensure accurate benefits are given, however, the benefits quoted to us by your insurance company are not a guarantee of payment.

I authorize the use of my signature on all Insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This content will end when my current treatment is completed or one year from the date signed below.

Patient Name: ______________________ Signature: ____________________________ Date: ___________

Parent/Guardian: ____________________ Signature: ____________________________Date: ___________

Witness Name: ______________________ 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.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed as your office visit.
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 my 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 disclosed.

Patient Name: ______________________ Signature: ____________________________ Date: ___________

Parent/Guardian: ____________________ Signature: ____________________________Date: ___________

Witness Name: ______________________ Signature: ____________________________ Date: ___________