Adult Member Health Record

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
MARITAL STATUS:	GENDER:
NUMBER OF CHILDREN & AGES:	HEIGHT: WEIGHT:
EMPLOYER NAME:	
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? ❑ YES # PACK/DAY ❑ NO

DO YOU DRINK ALCOHOL? ❑ YES # DRINKS/MONTH ❑ NO

DO YOU DRINK COFFEE, TEA OR SODA? ❑ YES # CUPS/DAY ❑ NO

DO YOU EXERCISE REGULARLY? ❑ YES # DAYS/WEEK ❑ NO

DO YOU EAT FAST FOOD? ❑ YES # OF MEALS/WEEK_____ ❑ NO

ARE YOU AWARE OF THE EFFECTS OF YOUR DIET ON YOUR OVERALL HEALTH? ❑ YES ❑ NO

WOULD YOU LIKE MORE INFORMATION ON THE EFFECTS OF DIET ON YOUR HEALTH? ❑ YES ❑ NO

DO YOU SLEEP WELL? ❑ YES ❑ NO # OF HOURS/DAY_____

HOW DO YOU SLEEP? ❑ BACK ❑ SIDE ❑ STOMACH

DO YOU WEAR:

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

CHIROPRACTIC HISTORY

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 CHECKED FOR VERTEBRAL SUBLUXATION?
❑ YES ❑ NO ❑ I DON'T KNOW

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 YOUR LAST VISIT:

HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

REASON FOR THIS VISIT: ❑ WELLNESS ❑ PAIN COMPLAINT
❑ AUTO/JOB INJURY ❑ NUTRITION

PLEASE DESCRIBE:

WHAT DATE DID THIS BEGIN?

DID THIS PROBLEM START:
❑ SUDDENLY ❑ GRADUALLY ❑ AFTER AN INJURY

HAS THIS CONCERN:
❑ GOTTEN WORSE ❑ BECOME CONSTANT/CHRONIC ❑ GOTTEN BETTER
❑ COME AND GONE

WHAT MAKES THE PROBLEM BETTER?

WHAT MAKES THE PROBLEM WORSE?

DOES THIS CONCERN INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

PLEASE DESCRIBE THE QUALITY OF THE PAIN (SHARP, DULLY ACHY, ETC.)

DOES THE PAIN RADIATE? ❑ YES ❑ NO
TO WHERE?

RATE THE SEVERITY OF THE PAIN (0=NO PAIN, 10=E.R. VISIT):

DOES THE PAIN CHANGE THROUGHOUT THE DAY? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS COMPLAINT? ❑ YES ❑ NO

PRIMARY DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS: ❑ GOOD ❑ BAD ❑ INDIFFERENT

Ballard Family Chiropractic 14225 E. Rickelman
Effingham, IL 62401

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT CHIROPRACTIC IS THE LARGEST ALTERNATIVE HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?
❑ YES ❑ NO

ARE YOU AWARE THAT CHIROPRACTORS TREAT A CONDITION CALLED SUBLUXATION?
❑ YES ❑ NO

DID YOU KNOW THAT YOU CAN HAVE A SUBLUXATION WITHOUT EXPERIENCING PAIN?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?
❑ 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. Please check the type of care desired so that we may be guided by your wishes whenever possible. **PLEASE PICK ONE**.

- ❑ **Relief care:** Symptomatic relief of pain or discomfort.
- ❑ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom or pain.
- ❑ **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 for my condition.***

PERSONAL HISTORY

DO YOU HAVE ANY DIAGNOSED DISEASES (HEART DISEASE, DIABETES, ETC.)? ? ❑ YES ❑ NO
PLEASE LIST:

DO YOU HAVE A HISTORY OF CAR ACCIDENTS, BROKEN BONES, FALLS OR OTHER TRAUMAS? ❑ YES ❑ NO
PLEASE LIST:

HAVE YOU HAD ANY SURGERIES? ❑ YES ❑ NO
PLEASE LIST WITH APPROXIMATE DATES:

ARE YOU CURRENTLY EXPERIENCING ANY MAJOR STRESS IN YOUR LIFE OTHERWISE UNLISTED ON THIS FORM? ❑ YES ❑ NO

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'.

OTHER SYMPTOMS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Headaches
Migraines
Dizziness
Sinus Problems
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:

_____

_____

_____

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE_____ ❑ M ❑ F ❑ S ❑ G

DEPRESSION ❑ M ❑ F ❑ S ❑ G

DIABETES ❑ M ❑ F ❑ S ❑ G

HEART DISEASE ❑ M ❑ F ❑ S ❑ G

LIVER DISEASE ❑ M ❑ F ❑ S ❑ G

HIGH CHOLESTEROL ❑ M ❑ F ❑ S ❑ G

HIGH BLOOD PRESSURE ❑ M ❑ F ❑ S ❑ G

LUNG PROBLEMS ❑ M ❑ F ❑ S ❑ G

SEIZURES ❑ M ❑ F ❑ S ❑ G

NECK PROBLEMS ❑ M ❑ F ❑ S ❑ G

BACK PROBLEMS ❑ M ❑ F ❑ S ❑ G

SCOLIOSIS ❑ M ❑ F ❑ S ❑ G

OSTEOARTHRITIS ❑ M ❑ F ❑ S ❑ G

RHEUMATOID ARTHRITIS ❑ M ❑ F ❑ S ❑ G

AUTOIMMUNE DISEASES ❑ M ❑ F ❑ S ❑ G

OTHER:_____

CURRENT MEDICATIONS

When properly prescribed medications mask the symptoms of disease & contribute to more than 100,000 deaths annually. Please list the medications you take and your dosage:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any supplements you are currently taking:

FEMALE PATIENTS

ARE YOU: ❑ CYCLING MONTHLY ❑ PERIMENOPAUSAL ❑ MENOPAUSAL

ARE YOU CURRENTLY PREGNANT? ? ❑ YES ❑ NO
IF YES, HOW FAR ALONG?_____WEEKS
DUE DATE:_____

ARE YOU CURRENTLY BREASTFEEDING? ? ❑ YES ❑ NO

ARE YOU CURRENTLY USING BIRTH CONTROL? ❑ YES ❑ NO

WHAT TYPE?

DO YOU:
EXPPERIENE PAINFUL PERIODS? ❑ YES ❑ NO
HAVE IRREGULAR CYCLES? ❑ YES ❑ NO
HAVE HEAVY/CLOTTY PERIODS? ❑ YES ❑ NO
HAVE SPOTTING BETWEEN CYCLES? ❑ YES ❑ NO
HAVE PAINFUL OR CRAMPY PERIDS? ❑ YES ❑ NO
EXPERIENCE INFERTILY? ? ❑ YES ❑ NO
PERFORM MONTHLY BREAST EXAMS? ❑ YES ❑ NO
HAVE ANNUAL MAMMOGRAMS? ❑ YES ❑ NO

YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS?

1._____

_____

2._____

_____

3._____

_____

IF THERE ARE ANY ISSUES THAT YOU ARE EXPERIENCING, OR THAT YOU HAVE CONCERNS ABOUT THAT HAVE NOT BEEN ADDRESSSED ON THESE FORMS, PLEASE WRITE THEM IN USING THE SPACE BELOW.

THANK YOU FOR CHOOSING BALLARD FAMILY CHIRORPACTIC AND HELPING US CONTINUE OUR MISSION TO ***GROW A HEALTHIER COMMUNITY, ONE FAMILY AT A TIME***!

INFORMED CONSENT AND AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. .

By signing below I agree to the above and allow the doctor, affiliated with Ballard Family Chiropractic, to perform such. This consent will cover the entire course of my treatment.

Patient Name: _____ *Date:*_____

FINANCIAL POLICY

Please read each statement and initial.

- I understand that I am personally financially responsible for all services rendered to me or my child. _____
- I agree that all fees will be paid at the time of service unless arrangements have been made in advance with Ballard Family Chiropractic. _____
- I understand if I carry a balance, a card must be kept on file with an authorization for a monthly payment as agreed upon with Ballard Family Chiropractic._____
- I understand if my balance exceeds $500 care may be suspended until financial arrangements have been made. _____

Patient Name: _____ *Date:*_____

To receive text appointment reminders, initial here_____

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. I also allow use of my personal email address for office communication.

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