



# ADULT 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 NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	OCCUPATION:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	

## ABOUT YOUR SPOUSE

SPOUSE NAME:	
SPOUSE EMPLOYER:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
OCCUPATION:	

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HOW DID YOU HEAR ABOUT OUR OFFICE (CHECK ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANYONE IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

## 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 my condition.*

## WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? <input type="checkbox"/> YES <input type="checkbox"/> NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? <input type="checkbox"/> YES <input type="checkbox"/> NO

## REASON FOR THIS VISIT

DESCRIBE THE PROBLEM OR CONDITION THAT IS CAUSING YOU TO SEEK CARE:
WHEN DID THIS CONDITION BEGIN?
HOW WOULD YOU CLASSIFY THIS CONDITION?: <input type="checkbox"/> MINOR <input type="checkbox"/> CHRONIC <input type="checkbox"/> SERIOUS <input type="checkbox"/> SEVERE
HAVE YOU EVER HAD THIS SAME OR SIMILAR PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES PLEASE EXPLAIN:
SELECT ANY OF THESE THAT DESCRIBE YOUR PAIN: <input type="checkbox"/> SHARP <input type="checkbox"/> STABBING <input type="checkbox"/> BURNING <input type="checkbox"/> DULL <input type="checkbox"/> SORE <input type="checkbox"/> WEAK <input type="checkbox"/> THROBBING <input type="checkbox"/> NUMB <input type="checkbox"/> SHOOTING <input type="checkbox"/> GRIPPING <input type="checkbox"/> TINGLING <input type="checkbox"/> CRAMPING <input type="checkbox"/> PINS & NEEDLES/PRICKLY <input type="checkbox"/> OTHER - PLEASE EXPLAIN:
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
SINCE THIS PROBLEM BEGAN, IS THE PAIN: <input type="checkbox"/> INCREASING <input type="checkbox"/> DECREASING <input type="checkbox"/> NOT CHANGING
DID THIS PROBLEM BEGIN: <input type="checkbox"/> IMMEDIATELY FOLLOWING A SPECIFIC INCIDENT <input type="checkbox"/> WITH MULTIPLE INCIDENTS <input type="checkbox"/> GRADUALLY OVER TIME
HAVE YOU SOUGHT OTHER TREATMENT FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S/THERAPIST'S NAME:
TYPE OF TREATMENT:
RESULTS:

## HEALTH CONDITIONS

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

<input type="checkbox"/> DIABETES	<input type="checkbox"/> BROKEN BONES	<input type="checkbox"/> SWELLING	<input type="checkbox"/> NOSE	<b>FOR WOMEN ONLY:</b>
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> STROKE	<input type="checkbox"/> BLOOD PRESSURE	<input type="checkbox"/> THROAT	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ULCER	<input type="checkbox"/> BRAIN/SPINAL CORD	<input type="checkbox"/> APPETITE	<input type="checkbox"/> CHEST	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> KIDNEY	<input type="checkbox"/> CANCER	<input type="checkbox"/> DERMATITIS	<input type="checkbox"/> FACE	ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> BLADDER	<input type="checkbox"/> BLURRY VISION	<input type="checkbox"/> URINATION	<input type="checkbox"/> PARALYSIS	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> HEART	<input type="checkbox"/> EARS RINGING	<input type="checkbox"/> DEFECACTION	<input type="checkbox"/> DIZZINESS	DO YOU:
<input type="checkbox"/> LUNGS	<input type="checkbox"/> CONFUSION	<input type="checkbox"/> SEXUAL ORGANS	<input type="checkbox"/> FAINTING	EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> STOMACH	<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SURGERIES:	HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LIVER	<input type="checkbox"/> CONVULSIONS	<input type="checkbox"/> DEPRESSION		HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> BOWEL	<input type="checkbox"/> EMOTIONAL	<input type="checkbox"/> SLEEP DISTURBANCE		OTHER HISTORY? <input type="checkbox"/> YES <input type="checkbox"/> NO
				IF YES, PLEASE EXPLAIN:

## HEALTH HABITS

DO YOU SMOKE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU DRINK ALCOHOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU WEAR:	<input type="checkbox"/> HEAL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS	

## MEDICATIONS YOU TAKE

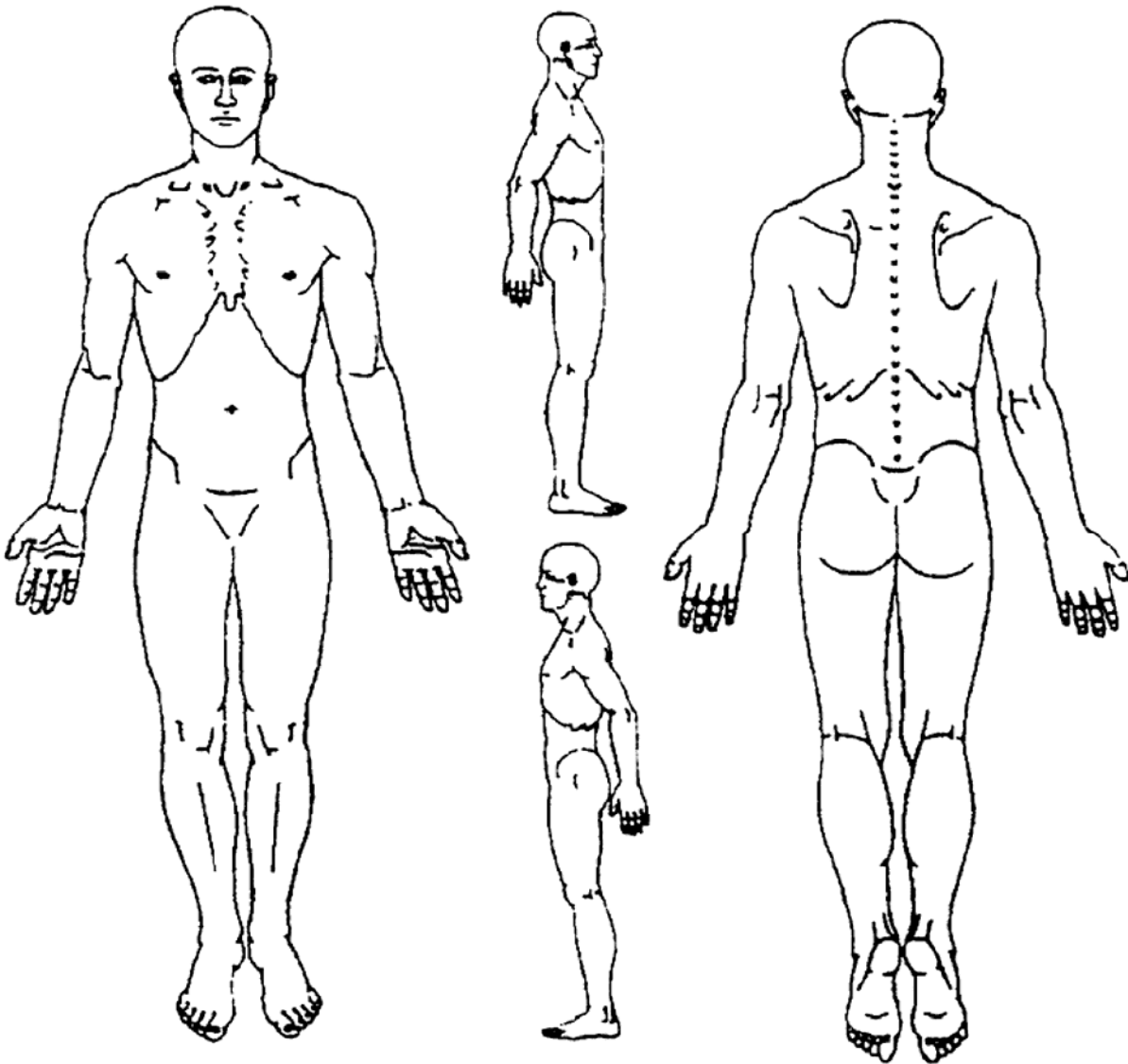
<input type="checkbox"/> ACETAMINOPHEN	<input type="checkbox"/> INSULIN
<input type="checkbox"/> ANTIBIOTICS	<input type="checkbox"/> STEROIDS
<input type="checkbox"/> ANTIHISTAMINES	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> RECREATIONAL DRUGS
<input type="checkbox"/> BLOOD THINNERS	<input type="checkbox"/> THYROID MEDICATION
<input type="checkbox"/> BLOOD PRESSURE MEDICATION	<input type="checkbox"/> TRANQUILIZERS
<input type="checkbox"/> COLD REMEDIES	<input type="checkbox"/> BIRTH CONTROL
<input type="checkbox"/> HEART MEDICATION	<input type="checkbox"/> ANTI-INFLAMMATORIES
<input type="checkbox"/> OTHERS & WHY:	
<input type="checkbox"/> VITAMINS & SUPPLEMENTS:	

## SUBJECTIVE ASSESSMENT

Please use the following symbols to accurately mark the areas on the image below in which you feel any of the described sensations. Include all affected areas.

Dull Pain: N N N    Stabbing/Cutting Pain: /// /// ///    Burning: X X X

Numbness: = = =    Tingling (pins & needles): : : : :    Cramping: S S S



## AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or 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. 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. 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 from 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.

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

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that we will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Health is a state of optimal physical, mental and social well being, not merely the absence of disease. Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

*I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.*

SIGNATURE:

DATE:

WITNESS 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.

*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:

# DiSC Style Assessment

EXAMPLE:

	Demanding Assertive	<b>L</b>	Outgoing Active	Kind Nice Caring	<b>M</b>	Proper Formal	
<b>1</b>	Firm Strong	<input type="checkbox"/>	Outgoing Active	Gentle Soft Humble	<input type="checkbox"/>	Law-abiding Conscientious	<input type="checkbox"/>
<b>2</b>	Brave Adventurous	<input type="checkbox"/>	Enthusiastic Influencing	Content Satisfied	<input type="checkbox"/>	Compliant By the book	<input type="checkbox"/>
<b>3</b>	Controlling Take charge	<input type="checkbox"/>	Persuading Convincing	Merciful Sensitive	<input type="checkbox"/>	Pondering Wondering	<input type="checkbox"/>
<b>4</b>	Convinced Cocky	<input type="checkbox"/>	Delightful Pleasant	Peaceful Calm	<input type="checkbox"/>	Conservative Inflexible	<input type="checkbox"/>
<b>5</b>	Determined Optimistic	<input type="checkbox"/>	Entertaining Clowning	Shy Mild	<input type="checkbox"/>	Competent Does right	<input type="checkbox"/>
<b>6</b>	Industrious Hard working	<input type="checkbox"/>	Smiling Happy	Timid Soft spoken	<input type="checkbox"/>	Systematic Follows plans	<input type="checkbox"/>
<b>7</b>	Decisive Sure Certain	<input type="checkbox"/>	Friendly Cordial Popular	Obedient Submissive	<input type="checkbox"/>	Careful Cautious	<input type="checkbox"/>
<b>8</b>	Winner Competitive	<input type="checkbox"/>	Admirable Elegant	Diplomatic Peacemaking	<input type="checkbox"/>	Contemplative Thinker	<input type="checkbox"/>
<b>9</b>	Outspoken Opinionated	<input type="checkbox"/>	Inducing Charming	Hospitable Enjoys company	<input type="checkbox"/>	Inventive Imaginative	<input type="checkbox"/>
<b>10</b>	Forceful Strong-willed	<input type="checkbox"/>	Hyper Energetic	Considerate Thoughtful	<input type="checkbox"/>	Perfectionist Precise	<input type="checkbox"/>
<b>11</b>	Challenging Motivating	<input type="checkbox"/>	Talkative Verbal	Steady Dependable	<input type="checkbox"/>	Accurate Exact	<input type="checkbox"/>
<b>12</b>	Zealous Eager	<input type="checkbox"/>	Exciting Spirited	Quiet Reserved	<input type="checkbox"/>	Organized Orderly	<input type="checkbox"/>
<b>13</b>	Will buy on impulse	<input type="checkbox"/>	Will spend as I want	Will wait, no pressure	<input type="checkbox"/>	Will do without, self-controlled	<input type="checkbox"/>
<b>14</b>	Bold Daring	<input type="checkbox"/>	Happy Carefree	Pleasing Kind	<input type="checkbox"/>	Cool Collected	<input type="checkbox"/>
<b>15</b>	Rules need to be challenged	<input type="checkbox"/>	Rules make it boring	Rules make it safe	<input type="checkbox"/>	Rules make it fair	<input type="checkbox"/>
<b>16</b>	Wants more authority	<input type="checkbox"/>	Wants new opportunities	Wants safety, security	<input type="checkbox"/>	Wants clear direction	<input type="checkbox"/>
<b>17</b>	A good delegator	<input type="checkbox"/>	A good encourager	A good listener	<input type="checkbox"/>	A good analyzer	<input type="checkbox"/>
<b>18</b>	Courageous Bold	<input type="checkbox"/>	Animated Laugh out loud	Please others Team player	<input type="checkbox"/>	Correct Exact	<input type="checkbox"/>

D

I

S

C

For Office Use Only

M  
L

## INSTRUCTIONS:

To the left are 18 word groupings that are associated with 4 main personality “styles”.

Read the words in each row and mark the word group that is **MOST** like you with an “M”. In that same row, mark the word that is **LEAST** like you with an “L”. You should have one “M” and one “L” in each row (see example).

## NOTE:

It is important that you **DO NOT** choose what you want to be, or what others think you are, but what YOU really are in YOUR real life.