

ADULT MEMBER UPDATE 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 AND ZIP CODE:
WORK PHONE:	POSITION TITLE:
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 AND ZIP CODE:
POSITION TITLE:	

HEALTH HABITS

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

CHIROPRACTIC EXPERIENCE

WHEN WAS YOUR LAST CHIROPRACTIC ADJUSTMENT?
WHAT WAS THE REASON FOR THE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANYONE IN YOUR FAMILY SEEN A CHIROPRACTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> JOB <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> WELLNESS
PLEASE EXPLAIN:
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
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:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

Healing Touch Chiropractic
158 W. Beaton Dr., Ste. 200
West Fargo, ND 58078

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WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?

YES NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?

YES NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?

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. 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.**

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS (INCLUDING ASPIRIN)
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER:
<input type="checkbox"/> INSULIN	<input type="checkbox"/> OTHER:
<input type="checkbox"/> VITAMINS & SUPPLEMENTS:	

YOUR CONCERNS

INSTRUCTIONS: Please circle the health concerns or conditions you may be experiencing now or in the past. Each area of concern relates to an area of the spine and nerve function.

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



C1 Headaches
Migraines
C2 Dizziness
C3 Sinus Problems
C4 Allergies
Fatigue
Head Colds
C5 Vision Problems
C6 Difficulty Concentrating
C7 Hearing Problems
T1

T2
T3 Middle Back Pain
T4 Congestion
T5 Difficulty Breathing
T6 Bronchitis
T7 Pneumonia
T8 Gallbladder Conditions
T9 Stomach Problems
T10 Ulcers
T11 Gastritis
T12 Kidney Problems

L1 Constipation
L2 Colitis
L3 Diarrhea
L4 Gas Pain
L5 Irritable Bowel
S Bladder Problems
A Menstrual Problems
C Low Back Pain
R Leg Pain or Numbness
A Reproductive Problems
L

OTHER:

HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect your customized care plan and the possibility of being accepted for care.

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

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Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve function through the adjustment of spinal subluxation(s).
- C. The chiropractic adjustment process, as defined in the “law of this jurisdiction” involves the application of a specific directional thrust to the spine.
- C. This is a safe, effective procedure applied over one-million times each day in the United States by doctors of chiropractic. Like all forms of health care, while offering considerable benefit, chiropractic may also provide some level of risk. This level of risk is minimal, yet injury can occur in rare cases.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type (s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, _____, have read and fully understand the above statements. I understand there may be risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient or Guardian Signature

Date

Witness Signature

Date

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BENEFIT AUTHORIZATION

I hereby authorize the Doctor to work with me 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 Healing Touch Chiropractic 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 Healing Touch Chiropractic will be credited to my account on receipt.

SIGNATURE:

DATE:

SIGNATURE OF GUARDIAN OR SPOUSE AUTHORIZING CARE:

DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

SELF SPOUSE PARENT WORKER'S 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 care and follow up with multiple healthcare providers who may be involved in that care.*
- *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:

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