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:
OCCUPATION:	
WORK PHONE:	PCP NAME:
PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

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

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

SUPPLEMENTS YOU TAKE

❑ ESSENTIAL FATTY ACIDS	❑ PROBIOTIC
❑ MULTIVITAMIN WHICH :_____	❑ OTHER_____
❑ CALCIUM / MAGNESIUM	❑ OTHER _____
❑ VITAMIN C	❑ OTHER _____

3113 S Taft Hill Rd, Fort Collins, CO 80526 • 970.530.0981 • www.accesstohealthfc.com

Access To Health

"The doors we open and close each day decide the lives we live."

*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'.*

ARE 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 for my condition.***

YOUR CONCERNS

Sore Throat
TMJ/Teeth Grinding
Neck Pain/Stiffness
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Elbow Pain
Heart Conditions
Pain Between Shoulders
Wrist pain/Carpal Tunnel

Constipation
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Knee Pain/Stiffness
Low Back Pain
Pain or Numbness in legs
Reproductive Problems
Ankle Pain/Stiffness
Hip Pain/Stiffness
Foot Pain/Issues
Buttocks Pain

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems/Ringing
ADD/ADHD
Insomnia

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Heartburn
Ulcers
Gastritis
Kidney Problems
Restless Leg Syndrome

OTHER:

_____

_____

_____

HEALTH CONDITIONS...

INSTRUCTIONS: *Please check each of the diseases or conditions that you now have now, have had in the past, or in your family history. 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.*

Self Family	Self Family	Self Family	Self Family
☐ SEVERE OR FREQUENT HEADACHES ☐	☐ ULCERS/COLITIS ☐	☐ PAIN/NUMBNESS IN ARMS/LEGS/HANDS ☐	☐ BLOOD & LYMPH NODE ISSUES ☐
☐ HEART ISSUES/ PACEMAKER ☐	☐ SINUS OR NOSE PROBLEMS ☐	☐ GLAND/HORMONE ISSUES ☐	☐ SHINGLES/ CHICKEN POX ☐
☐ LOWER BACK PROBLEMS ☐	☐ HEPATITIS ☐	☐ RHEUMATIC FEVER ☐	☐ DIABETES ☐
☐ FREQUENT NECK PAIN ☐	☐ CANCER ☐	☐ ALLERGIES ☐	☐ DIZZINESS ☐
☐ MOUTH OR THROAT ISSUES☐	☐ KIDNEY PROBLEMS ☐	☐ TUBERCULOSIS ☐	☐THYROID PROBLEMS☐
☐ DIGESTIVE PROBLEMS ☐	☐ EYE OR EAR ISSUES ☐	☐ ARTHRITIS ☐	☐ LOSS OF SLEEP ☐
☐ CONGENITAL HEART DEFECT ☐	☐ DIFFICULTY BREATHING/ASTHMA ☐	☐ LOW/HIGH BLOOD PRESSURE ☐	☐ SKIN/HAIR/NAIL ISSUES ☐

FOR WOMEN ONLY:

ARE YOU PRE- OR POST- MENAPAUSAL (CIRCLE ONE)?

ARE YOU PREGNANT? ❑ YES ❑ NO

IF YES, WHEN IS YOUR DUE DATE?

ARE YOU NURSING? ❑ YES ❑ NO

ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO

DO YOU:

EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO
HAVE IRREGULAR CYCLES? ❑ YES ❑ NO
HAVE BREAST IMPLANTS? ❑ YES ❑ NO
HAVE BREAST PROBLEMS? ❑ YES ❑ NO

PLEASE LIST ALL SURGERIES YOU HAVE HAD:

INFORMED CONSENT 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.

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

Patient Name: _____ *Date:*_____

*Patient or Guardian Signature:*_____ *Date:*_____

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.

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 will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGN IF READ ABOVE _____ 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.

Initial if the following applies: _____ I give my consent to provide medical information or financial information to my spouse/ partner _____(their name).

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

PATIENT AUTHORIZATIONS

If you choose not to authorize this information for official use, your decision will have no adverse effect on your care from Access to Health. These authorizations may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

1. It is our desire for our staff to use your name, address and telephone number for the purpose of contacting you to remind you about scheduled appointments, re-exams or other appointment related issues. A voice message may be left if unable to contact you in person. The use of this information is intended to make your experience with our office more efficient and productive and to further enhance your access to quality health care. Your signature indicates your authorization of this activity.

_____ _____ _____

Name (Print please.) Signature Date

2. It is our desire for our staff to use your name, address and e-mail address for the purpose of contacting you to send birthday cards, holiday letters and our monthly newsletter from the doctor and staff. The use of this information is intended to make your experience with our office more efficient and productive and to further enhance your access to quality health care. Your e-mail is not sold or shared. Your signature indicates your authorization of this activity.

_____ _____ _____

Name (Print please.) Signature Date

3. It is our desire to express our thanks to you when you refer in a patient by writing your name on our bulletin board in the reception room or in the newsletter. The use of this information is intended to enhance your experience in our office. Your signature indicates your authorization of this activity.

_____ _____ _____

Name (Print please.) Signature Date

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Access To Health

ACCIDENT DETAILS

What was the date of the accident?_____ What time did the accident occur?_____

How many vehicles were involved in the accident?_____ What was the estimated damage to your vehicle? _____

What state did the accident occur in? _____ What city did the accident occur in? _____

What street or intersection where you on when the accident occurred? _____

What direction were you traveling in? _____

Which part of your auto took the most impact)? _____

Did your vehicle hit anything after the accident? if yes, please describe _____

Where were you sitting in the vehicle during the accident? _____

Did you know the accident was coming, did you brace for impact?_____

What type of vehicle were you in (compact, mid, etc…)? _____

What type of vehicle impacted yours? _____

At the time of the impact, how fast was your vehicle moving? _____

At the time of impact, how fast was the other vehicle moving? _____

During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

Did you lose consciousness during the accident? _____

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

How were your hands positioned during the accident? _____

Did your head hit anything during the accident? _____ If yes, please describe_____

Did your face hit anything during the accident? _____ If yes, please describe_____

Did your shoulders hit anything during the accident? _____ If yes, please describe_____

Did your neck hit anything during the accident? _____If yes, please describe_____

Did your chest hit anything during the accident? _____ If yes, please describe_____

Did your hips hit anything during the accident? _____ If yes, please describe_____

Did your knees hit anything during the accident? _____ If yes, please describe_____

Did your feet hit anything during the accident? _____ If yes, please describe_____

Access To Health

ACCIDENT DETAILS

What kind of headrest was in your vehicle?
- movable fixed headrest - nonmovable fixed headrest - no headrest

Where was the headrest positioned on your head? _____

Did you have your seatbelt on during the accident? _____ Did you slide out of your seatbelt during the accident? _____

What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totaled
- side window	- front right door	
- rear window	- back left door	

Did any of the following dent inward?
- floorboards - side door - dashboard

Choose the doors that would not open as a result of the accident
- front left - front right - rear left - rear right

Did you go to the hospital? If no, why? (can skip the remaining questions) _____

How did get to the hospital? _____What was the name of the hospital? _____

Were you hospitalized overnight? _____

Circle what you were prescribed at the hospital
- pain medication - muscle relaxers - neck brace -other:_____

Did you receive any stitches for any cuts at the hospital? _____

Were x-rays taken at the hospital? _____ If yes, which area was taken? _____

INSURANCE DETAILS

At fault insured's name:_____ Group#:_____

At fault Insurance Co.:_____ Claim#:_____

Claims Address:_____ Adjuster:_____

_____ Ins. Co. Tel.#:_____

UM/UIM Policy Limits:_____

Who received citation?_____ Were the police notified? _____

Were there any witnesses? __Yes __No Is yes, Name _____

Name of Driver in Patient's vehicle (if passenger):_____

Does the driver of the car you were in have Med Pay? ___Yes ___No

If yes, telephone # of the driver's insurance: _____

Patient's Attorney's Name:_____

Address:_____

Telephone#:_____ Fax#:_____

NECK DISABILITY INDEX

Name_____ Date____/____/____ File #_____

(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

___ I have no pain at the moment.
___ The pain is very mild at the moment.
___ The pain is moderate at the moment.
___ The pain is fairly severe at the moment.
___ The pain is very severe at the moment.
___ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

___ I can look after myself normally without causing extra pain.
___ I can look after myself normally but it causes extra pain.
___ It is painful to look after myself and I am slow and careful.
___ I need some help but manage most of my personal care.
___ I need help everyday in most aspects of self care.
___ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

___ I can lift heavy weights without extra pain.
___ I can lift heavy weights but it gives extra pain.
___ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
___ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
___ I can only lift very light weights.
___ I cannot lift or carry anything at all.

SECTION 4 - Reading

___ I can read as much as I want to with no pain in my neck.
___ I can read as much as I want to with slight pain in my neck.
___ I can read as much as I want with moderate pain in my neck.
___ I can't read as much as I want because of moderate pain in my neck.
___ I can hardly read at all because of severe pain in my neck.
___ I cannot read at all.

SECTION 5 - Headache

___ I have no headaches at all.
___ I have slight headaches which come infrequently.
___ I have moderate headaches which come infrequently.
___ I have moderate headaches which come frequently.
___ I have severe headaches which come frequently.
___ I have headaches almost all the time.

SECTION 6 - Concentration

___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a lot of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot do any work at all.

SECTION 7 - Work

___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can hardly do any work at all.
___ I cannot do any work at all.

SECTION 8 - Driving

___ I can drive my car without any neck pain.
___ I can drive my car as long as I want with slight pain in my neck.
___ I can drive my car as long as I want with moderate pain in my neck.
___ I can't drive my car as long as I want because of moderate pain in my neck.
___ I can hardly drive at all because of severe pain in my neck.
___ I can't drive my car at all.

SECTION 9 - Sleeping

___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hr. sleepless).
___ My sleep is mildly disturbed (1-2 hrs. sleepless).
___ My sleep is moderately disturbed (2-3 hrs. sleepless).
___ My sleep is greatly disturbed (3-5 hrs. sleepless).
___ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - Recreation

___ I am able to engage in all my recreation activities with no neck pain at all.
___ I am able to engage in all my recreation activities, with some pain in my neck.
___ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
___ I am able to engage in a few of my usual recreation activities because of pain in my neck.
___ I can hardly do any recreation activities because of pain in my neck.
___ I can't do any recreation activities at all.

REVISED OSWESTRY DISABILITY

Name_____ Date____/____/____ File #_____

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

___ The pain comes and goes and is very mild.
___ The pain is mild and does not vary much.
___ The pain comes and goes and is moderate.
___ The pain is moderate and does not vary much.
___ The pain comes and goes and is severe.
___ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

___ I would not have to change my way of washing or dressing in order to avoid pain.
___ I do not normally change my way of washing or dressing even though it causes some pain.
___ Washing and dressing increase the pain, but I manage not to change my way of doing it.
___ Because of the pain, I am unable to do some washing and dressing without help.
___ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

___ I can lift heavy weights without extra pain.
___ I can lift heavy weights but it gives extra pain.
___ Pain prevents me from lifting heavy weights off the floor.
___ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
___ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
___ I can only lift very light weights at the most.

SECTION 4 - Walking

___ I have no pain walking.
___ I have some pain on walking but it does not increase with distance.
___ I cannot walk more than one mile without increasing pain.
___ I cannot walk more than 1/2 mile without increasing pain.
___ I cannot walk more than 1/4 mile without increasing pain.
___ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

___ I can sit in any chair as long as I like without pain.
___ I can sit only in my favorite chair as long as I like.
___ Pain prevents me from sitting more than 1 hour.
___ Pain prevents me from sitting more than 1/2 hour.
___ Pain prevents me from sitting more than 10 minutes.
___ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

___ I can stand as long as I want without pain.
___ I have some pain on standing, but it does not increase with time.
___ I cannot stand for longer than one hour without increasing pain.
___ I cannot stand for longer than 1/2 hour without increasing pain.
___ I cannot stand for longer than 10 minutes without increasing pain.
___ I avoid standing, because it increases the pain immediately.

SECTION 7 - Sleeping

___ I get no pain in bed.
___ I get pain in bed, but it does not prevent me from sleeping well.
___ Because of my pain, my normal night's sleep is reduced by less than 1/4.
___ Because of my pain, my normal night's sleep is reduced by less than 1/2.
___ Because of my pain, my normal night's sleep is reduced by less than 3/4.
___ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

___ My social life is normal and gives me no pain.
___ My social life is normal, but increases the degree of pain.
___ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g, dancing, etc.
___ Pain has restricted my social life and I do not go out very often.
___ Pain has restricted my social life to my home.
___ I have hardly any social life because of the pain.

SECTION 9 - Traveling

___ I get no pain while traveling.
___ I get some pain while traveling, but none of my usual forms of travel make it any worse.
___ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
___ I get extra pain while traveling which compels me to seek alternative forms of travel.
___ Pain restricts all forms of travel.
___ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

___ My pain is rapidly getting better.
___ My pain fluctuates, but overall is definitely getting better.
___ My pain seems to be be getting better, but improvement is slow.
___ My pain is neither getting better nor getting worse.
___ My pain is gradually worsening.
___ My pain is rapidly worsening.