MEMBER HEALTH RECORD

PERSONAL INFORMATION

Name:

Address:

City	State / Zip:
Home Phone: ( )	Cell Phone: ( )

Email:

Birth Date:	Age:
Marital Status:	Gender:
Number of Children:	Ages:

Employer's Name:

Employer Address:

Employer City:	Employer State/Zip Code:
Work Phone:	Position Title:

Payment Method: ❏ Cash ❏ Check ❏ Credit Card

ABOUT YOUR SPOUSE

Spouse Name:

Spouse Employer:

Position Title:

HEALTH HABITS

Do you smoke/chewing tobacco? If yes, how much	❏ YES ❏ NO per day
Do you drink alcohol? If yes, how much	❏ YES ❏ NO per week
Do you coffee, tea or soda?	❏ YES ❏ NO
Do you exercise regularly?	❏ YES ❏ NO

Do you wear:
❏ Heel lifts ❏ Sole lifts ❏ Inner soles ❏ Arch supports

CHIROPRACTIC EXPERIENCE

Have you seen or heard of our office because of ✔ all that apply:
❏ Internet ❏ Sign ❏ Web Page ❏ Community event

Who referred you to our office?

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 anyone in your family ever seen a chiropractor?

REASON FOR THIS VISIT

What are your objectives in consulting our office today?

Is the purpose for this appointment related to:
❏ Job ❏ Sports ❏ Auto ❏ Fall ❏ Home injury
❏ Chronic discomfort ❏ Wellness ❏ Other
Please explain:

If job related, have you made a report of your accident to your employer?
❏ Yes ❏ No

When did this condition begin?

Has this condition:
❏ Gotten worse ❏ Stayed consistent ❏ Come and gone

Does this condition interfere with:
❏ Work ❏ Sleep ❏ Daily routine ❏ Other activities
Please explain:

Has this condition occurred before? ❏ Yes ❏ No
Please explain:

Scale of 1-10, how would you rate your pain?

Have you seen other doctors for this condition? ❏ Yes ❏ No

Doctor's name:

Type or treatment:

Results:

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 me.**

MEDICATIONS YOU TAKE

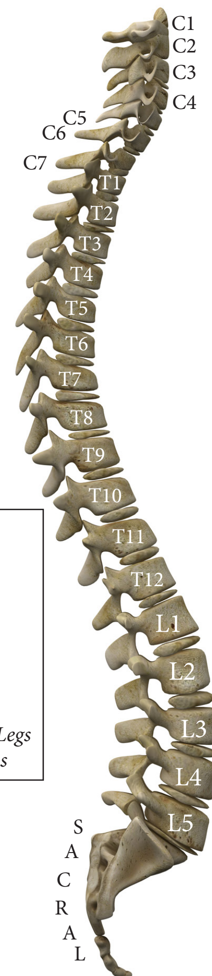
❑ Cholesterol medications	❑ Blood pressure medicine
❑ Stimulants	❑ Blood thinners
❑ Tranquillizers	❑ Pain killers (including Aspirin)
❑ Muscle relaxers	❑ Other:
❑ Insulin	❑ Other:
❑ Vitamins & Supplements:	

YOUR CONCERNS

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

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue / Sleep Problems
Head Colds
ADD / ADHD
Difficulty Concentrating
Autism

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



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

Constipation
Colitis
Infertility
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

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 the overall diagnosis, care plan and the possibility of being accepted for care.*

❑ Severe or frequent headaches	❑ Thyroid Problem	❑ Pain in arms/legs/hands	❑ Numbness
❑ Heart surgery/pacemaker	❑ Sinus problems	❑ Low blood pressure	❑ Allergies
❑ Lower back problems	❑ Hepatitis	❑ Rheumatic fever	❑ Diabetes
❑ Digestive problems	❑ Difficulty breathing	❑ Ulcer/Colitis	❑ Surgeries
❑ Pain between shoulders	❑ Kidney problems	❑ Tuberculosis	❑ Asthma
❑ Congenital heart defect	❑ High blood pressure	❑ Arthritis	❑ Loss of sleep
❑ Frequent neck pain	❑ Chemotherapy	❑ Shingles	❑ Dizziness

For women only:

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

WHAT ARE YOUR HEALTHCARE GOALS?

- ❏ **Increase energy**
- ❏ **Release weight**
- ❏ **Sleep better**
- ❏ **No more headaches**
- ❏ **Decrease pain**
- ❏ **Exercise more**
- ❏ **Less irritable**
- ❏ **More patience**
- ❏ **Be more active**
- ❏ **Be able to play with kids**
- ❏ **Improve relationship**
- ❏ **Perform better in school/better focus/ concentration**
- ❏ **Better athletic performance**
- ❏ **Other**

Please list of importance to you!

1.)

2.)

3.)

PATIENT HIPAA CONSENT FORM

Protecting the privacy or your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose 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 charges 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 and 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, and conduct normal healthcare operations such as a quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested, in writing, that you restrict how my personal information is used and disclosed.

Date: ____________________ Print Patient Name: ____________________

Signature: ____________________ Relationship to Patient: ____________________

FINANCIAL POLICY

Our Goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Cedar Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize the direct payment so Cedar Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me to Cedar Chiropractic based in whole or in pat upon the charges made for services received. I hereby appoint Cedar Chiropractic authority to endorse and cash checks, drafts or money orders made payable to the undersigned or as c-payee with this clinic for payments due for services rendered on behalf of the undersigned by Cedar Chiropractic.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- Late payment for non-coverage, deductible, and co-payment may be subject to an 18% annual finance charge, which will be added monthly to that account.
- If you have nay questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN).* Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our front desk. Signing below means that you have received ans understand this notice.

Date: ____________________ Signature: ____________________

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Cedar Chiropractic to treat my condition as deemed appropriate. At Cedar Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medial conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Cedar Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire in you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. AN attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can furtherassist you.

Date: ____________________ Signature: ____________________