Adult History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name_____ Today's Date _____

Birth Date _____Sex____ Weight_____ Height_____ Name You Go By _____

Please Check □ Married □ Single □ Other. Spouse/Partner name _____

# of children:_____ Names & ages: _____

Address _____

City _____ State _____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

How did you hear about our office? _____

Email Address_____ May we send you office newsletters □ Yes □ No

WHAT BRINGS YOU IN TODAY?

_____

(Your main complaint, concern or objective. We'll get more specific later)

YOUR WELLNESS OBJECTIVE

Besides addressing what's on the line above, do you most want to:

Meet the needs of my typical day	Exceed the needs of my typical day	Discover my very best

WORK & FAMILY HISTORY

Your Occupation: _____. Work Duties: _____.

Spouse's health status: _____. Children's health status: _____.

Past or present health problems of parents & siblings: _____.

Health History

Previous Chiropractor: _____ Rate your experience (1-10)? _____

Date of last visit & Reason: _____.

Name of Medical Doctor: _____. Rate your experience (1-10)? _____

Date of last visit &Reason: _____.

What other wellness professionals are currently parts of your health care team?

□ Massage Therapist □ Acupuncturist □ Naturopath □ Homeopath □ Other _____.

Indicate all prescription and non-prescription medicines you are taking:

☐ Asthma	☐ Cold/Allergy	☐ Anti-Depressant	☐ Blood Thinners
☐ Tylenol	☐ Blood Pressure	☐ Anxiety	☐ Hormones
☐ Advil/Ibuprofen	☐ Muscle Relaxors	☐ Sleep Aids	☐ Attention Aids

Other: _____.

Do you take any Vitamins or Herbs? □ Yes □ No _____.

CONSULTATION

Is this is from an auto or work related accident?. YES NO

Briefly give us more specifics as to why you are seeking chiropractic care: _____

_____

How severe/important is this to you? <*None* 1 2 3 4 5 6 7 8 9 10 *Severe*>

☐ Constant	☐ Occasional	☐ Dull	☐ Burning
☐ Frequent	☐ With motion	☐ Achy	☐ Numbness
☐ Intermittent	☐ Sharp	☐ Throbbing	

Other:_____.

Pain Radiates: No Yes, Where _____.

Has this happened before? No Yes When: _____ _____.

Do you have pain and/or difficulty performing any of the following activities

☐ personal care	☐ concentrating	☐ sleeping	☐ sitting
☐ lifting	☐ work	☐ recreation	☐ standing.
☐ reading	☐ driving	☐ walking	

Other professionals seen for this condition?_____.

Results with treatment?_____.

List any past surgeries and dates: _____.

Other Health Concerns or Complaints you would like to address_____

_____.

Many patients are surprised to find out that chiropractic care can help people with many of the conditions below. (Check all that apply)

☐ Dizziness	☐ Heart Problems	☐ Hyperactivity/ Behavioral	☐ Neck Problems
☐ Back Problems	☐ Anemia	☐ Fainting	☐ Arm problems
☐ Earaches	☐ Blood pressure	☐ Urinary problems	☐ Leg problems
☐ Diabetes	☐ Fatigue	☐ Bed Wetting	☐ Growing pains
☐ Breathing	☐ Asthma	☐ Loss of smell	☐ Irritability
☐ Colds/Flu	☐ Sinus/Allergies	☐ Muscle jerking	☐ Sore throats
☐ Migraines	☐ Numbness	☐ Walking problems	☐ Depression
☐ Arthritis	☐ Headaches	☐ Epilepsy	☐ Loss of balance
☐ Insomnia	☐ Digestive	☐ Colic	☐ Bronchitis
☐ Joint Pain	☐ Constipation		☐ Coordination
☐ Cancer	☐ Diarrhea		☐ Muscle Cramps
☐ Osteoporosis	☐ Poor Appetite		☐ Acid Reflux.

The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobbies) that could either begin or exacerbate subluxations. Help us discover a few of yours.

Car accidents 5+ ____ 3-4 ____ 1-2 ____ 0____ Date of most recent: _____.

Most significant injuries (from all events)_____.

Which of the following sports have you been involved in?

☐ Football	☐ Gymnastics	☐ Soccer	☐ Cheerleading
☐ Basketball	☐ Horseback	☐ Baseball	☐ Martial Art

Other:_____

☐ Broken a bone if so, which one? _____

☐ Sports injury

☐ Perform repetitive tasks (typing/lifting)

☐ Stress or strain while working

☐ Fallen down the stairs

☐ Sit more than 4 hours per day

☐ Slipped/Fell on the ground

☐ Drive more than 2 hours per day

☐ Exercise: ☐ 1-3x wk ☐ 4-7x wk. ☐ None. Member of a health club or gym? ☐ Yes ☐ No.

Is there any other injury to your spine, minor or major, that the Doctor should know about?

_____.

FEMALES ONLY

Are you pregnant? ☐ Yes ☐ No. If yes, due date: _____. Trying to get pregnant? ☐ Yes ☐ No.

Birth Control pills? ☐ Yes ☐ No. Date of last cycle_____. Days between your cycles: _____.

Do you have any of the following: (*circle all that apply*)

Backaches Reproductive problems Breast tenderness Migraines Constipation Irritability

Endometriosis Irregular cycles Painful cycles Other _____

Number of pregnancies ? _____. Number of miscarriages ? _____.

REGARDING PAYMENT AND AUTHORIZATION TO TREAT:

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making a collection 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. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize any Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid to the Doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any times while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office and agrees to pay minimal charges for all services and products rendered and to agree to arbitration for any disputes. Understand that the office may choose the arbitrator and both parties agree to abide by the arbitrator's decision. To waive the right of notice or exemption within the state of Alabama or any other state in regard to personal property , allows one and one half (1½%) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

Signature _____Date of signature_____

REGARDING PAYMENT AND AUTHORIZATION TO TREAT A MINOR:

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary, this includes radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my divorce separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Parent's Signature _____Date of Signature_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: 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 of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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 subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All 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)

Southern Pines Chiropractic Center
50 Manning Pl Birmingham, AL 35242
(205) 437-8837

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practice for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. Thereby give permission to Southern Pines Chiropractic Center (SPCC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to SPCC to use my address, phone number, email, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, newsletters, information about care alternatives or other health related information.
- If SPCC contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to SPCC to use my name on a welcome board, referral board, and birthday board.
- I give permission to SPCC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to SPCC to use any testimonial collected from me for marketing purposes such as sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give SPCC permission to deliver care to me in an open room where other patients are also present. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving SPCC permission to use and disclose your protected health information in accordance with the directives listed above. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Southern Pines Chiropractic Center plus 7 years or until revoked by me.

(more)

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of SPCC. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by SPCC for its own use/disclosure of PHI.(Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, SPCC will not refuse to provide services however, it will not be possible for SPCC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since SPCC will be unable to contact me 3) all contact with SPCC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries the protected health information to be used/disclosed A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization form and acknowledge receipt of the Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

DOB:_____

My name (please print):_____

My Signature: _____

Today's Date: _____

Name of personal Representative (if someone is designated to act on your behalf)

Name (please print): _____

Signature of Personal Representative: _____

Description of Representative's Authority to Act on Patient's Behalf: _____

_____