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:	SPOUSE'S NAME:
EMPLOYER NAME:	
EMPLOYER ADDRESS/CITY/STATE/ZIP	
WORK PHONE:	POSITION TITLE:
EMERGENCY CONTACT:	EMERGENCY PHONE :
INSURED'S NAME	DOB:
NAME OF INSURANCE	
CONTRACT NUMBER	MEMBER ID

PRIMARY CARE PROVIDER

PROVDER NAME:	
PROVIDER ADDRESS:	
CITY:	STATE/ZIP CODE:
PHONE:	

HEALTH HABITS

DO YOU SMOKE? ❑ YES ❑ NO If yes, how much per day_____

DO YOU DRINK ALCOHOL? ❑ YES ❑ NO If yes, how much per week_____

HEIGHT _____ WEIGHT _____

DOMINANT HAND R_____L____

DO YOU EXERCISE REGULARLY? ❑ YES ❑ NO

DO YOU WEAR:

❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):

❑ INTERNET ❑ 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 ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

❑ JOB ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY
❑ CHRONIC DISCOMFORT ❑ 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 CONSTANT ❑ 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:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

Goshorn Chiropractic & Wellness
725 Ridge Road
Webster, NY 14580

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.

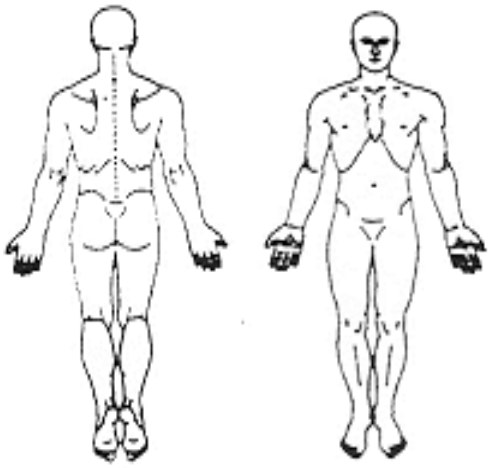
- ❑ **Relief care:** Symptomatic relief of pain or discomfort.
- ❑ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- ❑ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ❑ ***I want the Doctor to select the type of care appropriate for***

MEDICATIONS YOU TAKE

❑ CHOLESTEROL MEDICATIONS	❑ BLOOD PRESSURE MEDICINE
❑ STIMULANTS	❑ BLOOD THINNERS
❑ TRANQUILIZERS	❑ PAIN KILLERS (INCLUDING ASPIRIN)
❑ MUSCLE RELAXERS	❑ ANTIDEPESSANTS/ PSYCHOTHERAPEUTIC:
❑ INSULIN	❑ OTHER:
❑ VITAMINS & SUPPLEMENTS:	

INSTRUCTIONS: *BY USING THE KEY BELOW, INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCEING THE FOLLOWING SYMPTOMS:*

# = NUMBNESS X = BURNING / = STABBING
0 = PINS & NEEDLES + = DULL ACHE



Using a scale in which **"0" is none** (no pain or symptoms)
and **"10" is severe** pain or symptoms
circle the number that best reflects your condition:
none …..……..to ……severe
0 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that you or your family 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.*

	SELF	FAMILY		SELF	FAMILY
SEVERE OR FREQUENT HEADACHES			THYROID PROBLEMS		
HEART SURGERY/ PACEMAKER			SINUS PROBLEMS		
LOWER BACK PROBLEMS			HEPATITIS		
DIGESTIVE PROBLEMS			DIFFICULTY BREATHING		
PAIN BETWEEN SHOULDERS			KIDNEY PROBLEMS		
CONGENITAL HEART DEFECT			HIGH BLOOD PRESSURE		
FREQUENT NECK PAIN			CHEMOTHERAPY		
PAIN IN ARMS/LEGS/HANDS			NUMBNESS		
LOW BLOOD PRESSURE			ALLERGIES		
RHEUMATIC FEVER			DIABETES		
ULCERS/COLITIS			SURGERIES:		
TUBERCULOSIS			ASTHMA		
ARTHRITIS			LOSS OF SLEEP		
SHINGLES			DIZZINESS		

FOR WOMEN ONLY:

ARE YOU PREGNANT? OR PLANNING TO BE? ❑ 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

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 towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they 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.

NAME OF INDIVIDUAL YOU ARE GRANTING ACCESS TO YOUR INFORMATION A)	PHONE NUMBER : RELATIONSHIP TO PATIENT:
B)	PHONE MUNBER: RELATIONSHIP TO PATIENT:
PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

ADDITIONAL NOTES: