

# Adult Member Health Record

Adult Member Health Record (page 1 of 4)

Most of this editable PDF can be filled out on your computer. Please fill out, print, sign & date, and bring to your appointment.

Aligned for Life Chiropractic  
91 Newport Pike, Suite 305  
Gap, PA 17527  
(717) 435-3935



## 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 ADDRESS:		
WORK PHONE:	POSITION TITLE:	
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD		

## ABOUT YOUR SIGNIFICANT OTHER

SIGNIFICANT OTHER:
EMPLOYER:
POSITION TITLE:

## HEALTH HABITS

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

## MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER _____

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (CHECK ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> 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: <u>IF YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE:</u> <input type="checkbox"/> WELLNESS <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> JOB <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
WHEN DID THIS CONCERN BEGIN?
HAS THIS CONCERN: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONCERN INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONCERN OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT

## SUPPLEMENTS YOU TAKE

<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<input type="checkbox"/> PROBIOTIC
<input type="checkbox"/> MULTIVITAMIN WHICH: _____	<input type="checkbox"/> OTHER
<input type="checkbox"/> CALCIUM / MAGNESIUM	<input type="checkbox"/> OTHER
<input type="checkbox"/> VITAMIN C	<input type="checkbox"/> OTHER

Many problems and health challenges can start as ‘nerve interference’ blocking the vital power that operates and heals our body. Under ‘Your Concerns’ and ‘Health Conditions’, please check off 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?
<input type="checkbox"/> YES <input type="checkbox"/> NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?
<input type="checkbox"/> YES <input type="checkbox"/> NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?
<input type="checkbox"/> YES <input type="checkbox"/> 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.

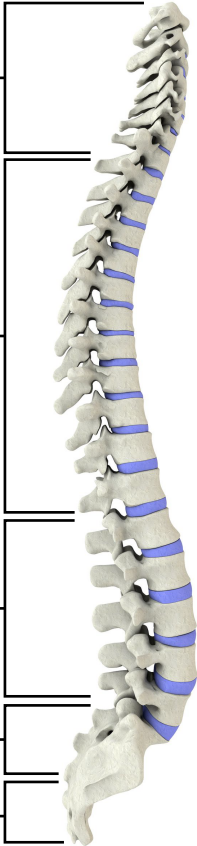
☐ Relief Care: Symptomatic relief of pain or discomfort.

☐ 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

<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Headaches	
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Migraines	
<input type="checkbox"/> Radiating Arm Pain	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Hand/Finger Numbness	<input type="checkbox"/> Sinus Problems	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Vertigo	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fatigue	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Head Colds	
<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Vision Problems	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty Concentrating	
<input type="checkbox"/> Colitis	<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Congestion	
<input type="checkbox"/> Gas Pain	<input type="checkbox"/> Difficulty Breathing	
<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Bronchitis	
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Gallbladder Conditions	
<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Stomach Problems	
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Pain or Numbness in Legs	<input type="checkbox"/> Gastritis	
<input type="checkbox"/> Reproductive Problems	<input type="checkbox"/> Kidney Problems	
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 the overall diagnosis, 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"/> ALLERGIES	
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES	
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	
				ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
				IF YES, WHEN IS YOUR DUE DATE?
				ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO
				ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO
				DO YOU: EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)				

## STATEMENT OF FINANCIAL UNDERSTANDING

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.

Patients with chiropractic insurance will be expected to pay any deductible or coinsurance amount they owe on the date of service. I understand that if there is a problem with my insurance I will pay ***Aligned for Life Chiropractic*** for any outstanding charges. ***Aligned for Life Chiropractic*** has no control over the payment of your claim by your insurance company. If you do not carry insurance we ask that **all charges be paid at the time of service.**

Auto accident and workers compensation claims will be billed entirely to the insurance company. However, it is your responsibility to obtain the proper forms and notify your employer and/or insurance company of the injury/accident. If the claim should be denied or rejected I understand that I'm responsible for the payment of all charges.

Sign if Read Above \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their own PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained for one time for all the subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your own security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures and our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with a privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient of authorize signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
- b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulations is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

- a. The condition that the treatment is to address;
- b. The nature of the treatment;
- c. The risks and benefits of that treatment; and
- d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend his consent to apply to all my present and future care with Dr. Sekora Wallace-Henderson.

Dated this \_\_\_\_ day of 20\_\_\_\_.

\_\_\_\_\_  
Patient Signature (or Legal Guardian)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Print Name: