

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	
AGE:	
RELATIONSHIP STATUS:	GENDER:
SPOUSE/PARTNER'S NAME	NUMBER OF CHILDREN:
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	

ABOUT YOUR HEALTH TEAM

PRIMARY CARE PHYSICIAN:
OTHER PRACTITIONERS, SUCH AS ACUPUNCTURIST, NATUROPATH, ETC.:
WOULD YOU LIKE US TO COMMUNICATE OUR TREATMENT TO ANY ONE ELSE ON YOUR CARE TEAM?

HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per day _____
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per week _____
DO YOU DRINK COFFEE, TEA, OR SODA	If yes, how much per day _____
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHAT KINDS OF EXERCISE HAVE YOU DONE IN THE PAST?	
<input type="checkbox"/> WALKING <input type="checkbox"/> WEIGHTS <input type="checkbox"/> YOGA <input type="checkbox"/> SWIMMING <input type="checkbox"/> OTHER	

WELLNESS EXPERIENCE

WHO REFERRED YOU TO OUR CLINIC?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> INTERNET <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN TREATED BY A CHIROPRACTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
PRACTITIONER'S NAME(S)
APPROXIMATE DATE OF LAST VISIT:
HAS YOUR FAMILY HAD EXPERIENCE WITH NATURAL HEALTH CARE?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> JOB <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN ANY ONE ELSE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
PRACTITIONER'S NAME:
TYPE OF TREATMENT:
RESULTS:

3 Bears Chiropractic & Wellness, Located at **The Healing Garage LLC**

2913 HARRIET AVE S, SUITE 103
MINNEAPOLIS, MN 55408

WERE YOU AWARE THAT...

THE TRAINING OF YOUR CHIROPRACTOR PARALLELS THAT OF YOUR MEDICAL DOCTOR, BUT WITH AN EMPHASIS IN NON-INVASIVE OPTIONS?

YES NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?

YES NO

NUTRITION HELPS TO PREVENT CHRONIC DISEASE AND ENHANCE HEALING?

YES NO

GOALS FOR YOUR CARE

People seek integrative care 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 Practitioner 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 and massage therapy.
- I want the Doctor or Practitioner to select the type of care appropriate for my condition.**

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS (INCLUDING ASPIRIN)
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> ANTIDEPRESSANTS:
<input type="checkbox"/> INSULIN	<input type="checkbox"/> OTHER:
<input type="checkbox"/> 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.

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

C1
C2
C3
C4
C5
C6
C7
T1

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

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

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

L1
L2
L3
L4
L5
S
A
C
R
A
L

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	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	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
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	

AUTHORIZATION FOR CHIROPRACTIC CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as 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.*

SIGNATURE:

DATE:

GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:

DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

- PATIENT
 SPOUSE
 PARENT
 WORKERS COMP INSURANCE
 AUTO INSURANCE
 MEDICARE
 HEALTH

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 primary 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 via phone or email 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.

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

PATIENT CASE HISTORY

FOR OFFICE USE ONLY

CHIEF CONCERNS:
HISTORY OF CONDITION:
ASSOCIATED SYMPTOMS:
AGGRAVATING FACTORS:
WHAT HAS BEEN DONE TO HELP THIS CONDITION:
PRIOR ILLNESS, SURGERY, ACCIDENTS:
FAMILY HEALTH HISTORY:
OTHER:

SYSTEMS CHECK COMPLETE

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