ROCHESTER FAMILY CHIROPRACTIC

www.RochesterFamilyChiro.com

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Chiropractic is the health care profession that focuses on the proper alignment of the spine, eliminating nervous system interference and allowing true health to be expressed.

ADULT HEALTH HISTORY

Today's Date:______________________________

Name: ____Social Security Number: ______________________
First Middle Last

Address: ____
Street City State Zip Code

Gender: ( )Female ( )Male Birth Date: _____/_____/_____ Age: _________

Home Phone: ______________________Work Phone: _____________________Cell Phone:______________________

Email:____ Marital Status:______________________

Your Employer: ____Occupation: ____________________________

How did you hear about us? ________________________ If referred, whom may we thank? ______________________

Whom should we contact in case of an emergency? ____

Relationship to you? _______________________________________Phone: _____________________________________

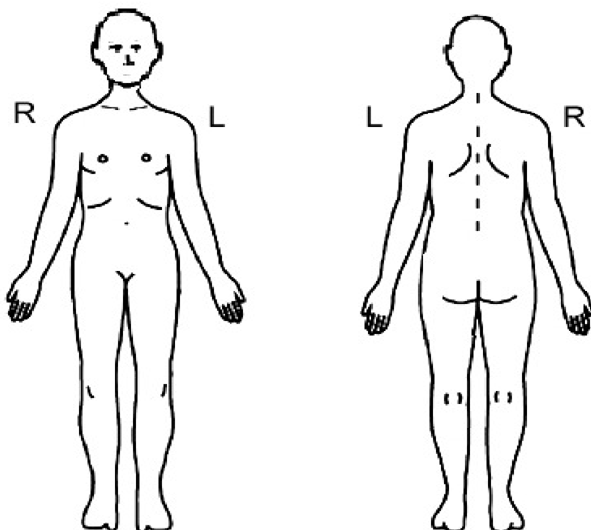
PURPOSE FOR CONTACTING US:

Please √ ( )Spinal Well-care/prevention or ( )Other (please explain): ____

Date you first noticed the symptoms? _______________________________________))))___________________________

Where specifically is the problem(s) located?____

Please mark below the location(s) of symptoms:



Circle your symptoms: sharp / dull / throbbing / numbness aching / shooting / burning / tingling / cramps stiffness / swelling / Other:_________________________
____

Have you received any of the following?
( )Medication ( )Surgery ( )Physical Therapy
Other:____

Circle the severity of your symptom(s):
0 /none - 1 - 2 - 3 - 4 - 5 - 6 - 7 – 8 - 9 – 10/extreme

Do you have difficulty with? ( )Sitting ( )Standing
( )Walking ( )Bending ( )Lying Down ( )Sleeping

Is the pain? ( )constant or ( )comes and goes

Is this condition getting progressively worse? ( )Yes ( )No

Does it interfere with? ( )work ( )sleep ( )recreation
( )daily routine

Are your symptoms? ( )local ( )radiating

Other doctor(s) whom you have seen for this condition?
(name and dates)
____
____

Have you had previous chiropractic care? ( )No ( )Yes
If yes, please list name, date and reason:
____
____

Please list ALL surgeries you have had (with dates):
____
____
____

Please list ALL accidents (including auto), injuries and falls (with dates):

____________________ ____________________

____________________ ____________________

HEALTH HISTORY

	Self	Family		Self	Family		Self	Family
Allergies	___	___	Herniated Disc	___	___	Osteoporosis	___	___
Arthritis(Osteo/Rheu)	___	___	High Blood Pressure	___	___	Pinched nerve	___	___
Asthma	___	___	High Cholesterol	___	___	Stroke	___	___
Bleeding Disorder	___	___	Infertility	___	___	Seizures	___	___
Cancer:___________	___	___	Kidney Disease	___	___	Thyroid problem	___	___
Diabetes	___	___	Liver Disease	___	___	Tumors, Growths	___	___
Fracture:___________	___	___	Mental Illness	___	___	Ulcers	___	___
Heart Disease	___	___	Migraine Headaches	___	___	Other: ____________________		

Date of last physical exam?__________________________ Height?______________ Weight?_______________

Please list your current medications and for what conditions they have been prescribed:

____________________ ____________________

____________________ ____________________

____________________ ____________________

Allergies:____

Women: Date of last menstrual cycle?_____________ Onset of Menopause:___________

Are you pregnant? ( )No ( )Yes, how many weeks?_________ Due Date: _________ Nursing? ( )No ( )Yes

DAILY HABITS

Describe your daily work habits: ( )sitting, ( )standing, ( )light or heavy labor, ( )computer, ( )other:_______________

What exercise do you do on a daily basis? ___________________________________ How long? _______________

Do you smoke? ( )No ( )Yes, how much/day?______ How much alcohol consumed on a weekly basis? _____________

Soda/coffee drinks per day? ________ Describe your stress level? ( )none ( )low ( )moderate ( )high

Do you take vitamins/supplements? ( )No ( )Yes, type and how often?______________________________________

How many hours of sleep do you get a night?_________ Describe the quality? ( )Poor ( )Good

In what position do you sleep? ( )Back ( )Side ( )Stomach

What activities can you no longer do due to your current health condition? _____________________________________

____

Thank you for choosing Rochester Family Chiropractic to be your health-care partner.
We are here to serve you and your family. If you have questions or concerns please let us know.
Your participation is vital and will help determine your health results.

CONSENT TO CHIROPRACTIC CARE

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Laura Nicholson, D.C. and/or any other chiropractic personnel who may be involved in the course of my treatment. Procedures may include the following: patient history, patient exam with orthopedic, neurological and chiropractic assessment, diagnostic x-rays, report of findings, chiropractic adjustments, heat and cold therapy, therapeutic massage and reassessment exams. I understand that Dr. Nicholson and/or personnel will rely on statements about me, my medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that with all health care delivery systems, including medicine, the practice of chiropractic may have potential complications. Possible risks may include post-treatment soreness, disc injury aggravation, joint, ligament, tendon or soft tissue injury and osseous tissue injury. As for a risk of stroke, according to the journal, *Spine* 2008; 33 (4S):S176-S183, patients are no more likely to suffer a stroke following a visit to a chiropractor than they would after stepping into their family doctor's office. The potential incidence is so rare that it is considered statistically insignificant. Precautions such as pre-treatment history, examination, and x-rays prior to care minimize such risks, as well as performing all treatment carefully. Please advise your doctor if you experience any soreness, discomfort, dizziness, headache, tiredness, nausea, vomiting, loss of balance, or any other side effects or symptoms.

I understand that chiropractic care involves the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me. I wish to rely on Dr. Nicholson to exercise judgment during the course of the procedure which she feels at the time, based upon the facts then known, is in my best interests. I have had an opportunity to discuss to my satisfaction with Dr. Nicholson, or other clinic personnel the nature and purpose of chiropractic adjustments and therapy procedures. By signing this form, I acknowledge that I have read or had this form read and/or explained to me and that I fully understand its contents.

____

Printed Name Signature Date

VERIFICATION OF NON-PREGNANCY (WOMEN ONLY)

I verify to the best of my knowledge I am not pregnant at this time and have given my permission to perform diagnostic x-rays.

____

Printed Name Signature Date

AUTHORIZATION OF PAYMENT

I authorize and request my insurance carrier to pay directly to Rochester Family Chiropractic insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

____

Printed Name Signature Date

NOTICE OF PRIVACY PRACTICES

I acknowledge that Rochester Family Chiropractic "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review Rochester Family Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practice describes the types of use and disclosures of my protected health information that will occur in my care, payment of my bills and/or in the performance of health care operations of Rochester Family Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practice for Rochester Family Chiropractic is available at the main administrative desk of this practice. Rochester Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised notice of privacy practices by calling the office and requesting a copy.

____

Printed Name Signature Date

____

Office Personnel/Witness Signature Date