ADULT HEALTH RECORD

Welcome to Olar Family Chiropractic!

File Number:__________

Name:____ Date:______________
Address:______________________________City:____________ State:______ ZIP:__________
E-mail:____ Date of Birth: _____/______/_____
Cell #: _________________ Home #:____________________ Work #:____________________
Occupation:_________________________ Employers Name:_____________________________
Marital Status: S M D W Spouse Name:__________________________ # of Children:_______

Insurance:

Primary Insurance Name:__________________
Policy #:_______________ Group #:____________
Policy Holder Name:________________ DOB:___/___/___
Relationship:_____________

Secondary Insurance Name:__________________
Policy #:_______________ Group #:____________
Policy Holder Name:________________ DOB:___/___/___
Relationship:_____________

Reason For Visit?: ____

When did it start?:_________________________ Has this occurred before? ☐ YES ☐ NO
How it began:____

Sensations are: ☐ SHARP ☐ DULL ☐ THROBBING ☐ NUMBNESS ☐ PAIN TRAVELS ☐ OTHER:_____________
Has this condition: ☐ GETTING BETTER ☐ GETTING WORSE ☐ STAYED CONSTANT ☐ COMES AND GOES
Activities or movements that are painful to perform: ☐ SITTING ☐ WALKING ☐ BENDING ☐ LYING DOWN
Does this condition interfere with: ☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER ACTIVITIES:_____________________________

Health Profile:

Describe your quality of sleep: ☐ POOR ☐ SPORADIC ☐ AVERAGE ☐ GOOD ☐ EXCELLENT Hours of sleep per night:____
Sleeping posture: ☐ SIDE ☐ STOMACH ☐ BACK

How would you rate your:
Diet ☐ POOR ☐ GOOD ☐ EXCELLENT
Exercise ☐ POOR ☐ GOOD ☐ EXCELLENT

Do you use any of the following? ☐ TOBACCO amt_____/day ☐ ALCOHOL amt_____glass/wk _____shots/wk ☐ COFFEE amt_____cups/day ☐ SODA amt_____cups/day
Are you following any special diet? ☐ YES ☐ NO Describe if marked Yes:_____________________________

Stress: Physical: (Circle) 0 1 2 3 4 5 6 7 8 9 10
(MILD) (MODERATE) (SEVERE)

Emotional: 0 1 2 3 4 5 6 7 8 9 10
(MILD) (MODERATE) (SEVERE)

Ever involved in any high impact or contact type sports? ☐ YES ☐ NO, List_____________________________

Auto accidents? ☐ YES ☐ NO, List: ____

Other injuries? ☐ YES ☐ NO , List: ____

Prior Surgeries?: ☐ YES ☐ NO , List: ____
Or Hospitalizations

Conditions:

Check (√) conditions you have currently or have had in the past 2 years:

☐ Appetite Changes	☐ Dizziness	☐ Headaches	☐ Infections	☐ Shortness of Breath
☐ Appendicitis	☐ Ears Ring	☐ Irritability	☐ Neck Pain	☐ Sleeping Problems
☐ Back Pain	☐ Face Flushed	☐ Light Bothers Eyes	☐ Numbness in Toes	☐ High Blood Pressure
☐ History of Falling	☐ Fatigue	☐ Loss of Balance	☐ Numbness in Fingers	☐ Tension
☐ Chest Pains	☐ Feet Cold	☐ Loss of Smell	☐ Pneumonia	☐ Thyroid problems
☐ Cold Sweats	☐ Fever	☐ Loss of Taste	☐ Pins & needles in arms	☐ Vision disturbances
☐ Constipation	☐ Gout	☐ Liver Disease	☐ Pins & needles in legs	☐ Diabetes
☐ Depression	☐ Hands Cold	☐ Miscarriage	☐ Rheumatoid arthritis	☐ Loss of Weight

☐ Other:____

Check (√) conditions if you have ever had in the past?:

☐ STROKE	☐ CANCER	☐ HEART DISEASE	☐ SPINAL SURGERY
☐ SEIZURES	☐ SPINAL BONE FRACTURE	☐ SCOLIOSIS	☐ DIABETES

(Explain If marked):____

____

Family History:

	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	OTHER
Father's Side	☐	☐	☐	☐	☐ :___________________
Mother's Side	☐	☐	☐	☐	☐ :___________________

Medications:

☐ CHOLESTEROL	☐ BLOOD PRESSURE	☐ STIMULANTS	☐ BLOOD THINNERS
☐ TRANQUILIZERS	☐ PAIN KILLERS (INCLUDING ASPRIN)	☐ MUSCLE RELAXERS	☐ INSULIN
☐ OTHER:______________________	☐ OTHER:____________________	☐ Other:______________________________	

Vitamins/Supplements:

☐ Vitamin A	☐ Vitamin B	☐ Vitamin C	☐ Vitamin D
☐ Vitamin E	☐ Vitamin K	☐ CoQ 10:	☐ Multi-Vitamin
☐ Omega 3:______________________	☐ Calcium:____________________	☐ Other:____________________________	

What changes in your health would you like to accomplish?____

____

Survey Questions:

Who may we thank for referring you to our clinic?____

You seen or heard of our office because of: ☐ NEWSPAPER ☐ PHONE BOOK ☐ COMMUNITY EVENT ☐ INTERNET ☐ BENCH BILLBOARD ☐ TV

Was it easy to locate the clinic?: ☐ YES ☐ NO

Have you been adjusted by a chiropractor before? ☐ YES ☐ NO

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 (HIPPA), 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 physicians'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:**

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 OJECTIVE 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.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

I authorize the release of any chiropractic or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I also authorize direct payment of chiropractic benefits to the chiropractor of services.

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:**

AUTHORIZATION FOR CARE OF MINOR

I, ____________________________ being the parent or legal guardian of __________________________have read and fully understand the above Informed Consent and hereby grant permission for my child/children to receive chiropractic care.