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:
MARITIAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD	

WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?
❑ YES ❑ NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?
❑ YES ❑ NO

HEALTH HABITS

DO YOU SMOKE?
❑ YES ❑ NO

DO YOU DRINK ALCOHOL?
❑ YES ❑ NO

DO YOU DRINK COFFEE, TEA OR SODA?
❑ YES ❑ NO

DO YOU EXERCISE REGULARLY?
❑ YES ❑ NO

DO YOU WEAR:
❑ HEAL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECASE OF (ALL THAT APPLY):
❑ NEWSPAPER ❑ 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

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER?
❑ YES ❑ NO

WHEN DID THIS CONDITION BEGIN?
❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ DAILY ROUTINE ❑ OTHER ACTIVITIES

HAS THIS CONDITION OCCURRED BEFORE? YES 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 appropriate for my condition.***

Croixview Family Chiropractic
113 2ND Street
Hudson, WI 54016

Health Conditions

Patient Name:_____ Date_____

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary problems
❑	❑	Migraines	❑	❑	Easy bruising
❑	❑	Shortness of breath	❑	❑	Tobacco Use
❑	❑	Allergies/Asthma	❑	❑	Dental problems
❑	❑	Medication side affects	❑	❑	Fibromyalgia
❑	❑	Hands or Feet cold	❑	❑	Blood thinner use
❑	❑	Muscle Aches	❑	❑	HIV positive
❑	❑	Trouble Walking	❑	❑	Cancer
❑	❑	Leg/Foot numbness	❑	❑	Depression
❑	❑	Fainting	❑	❑	Alcohol use
❑	❑	Gall bladder trouble	❑	❑	____high or ____low Blood pressure
❑	❑	Ringing in ears	❑	❑	Stroke history
❑	❑	Ear Problems	❑	❑	High cholesterol
❑	❑	Sleeping problems	❑	❑	TMJ
❑	❑	Vision problems	❑	❑	Digestive problems
❑	❑	Thyroid problems	❑	❑	Pain all over
❑	❑	Liver disease	❑	❑	Tension/Irritability
❑	❑	Kidney problems	❑	❑	Chest pains
❑	❑	Light bothers eyes	❑	❑	Heart Pacemaker
❑	❑	Other _____	❑	❑	Heart problems

LIST MEDICATIONS/SUPPLEMENTS:

LIST DOCTORS YOU ARE SEEING:

Present complaints:

1._____ How long has this been an issue?_____

Is it: (circle all that apply) Dull Mild Severe worse in morning worse in evening Pain radiates to _____

2._____ How long has this been an issue?_____

Is it: (circle all that apply) Dull Mild Severe worse in morning worse in evening Pain radiates to _____

3._____ How long has this been an issue?_____

Is it: (circle all that apply) Dull Mild Severe worse in morning worse in evening Pain radiates to _____

Does your condition affect: (circle all that apply) Sleep Work Daily Routine Sitting Driving

What makes it Better?_____

What makes it worse?_____

What doctors have you seen for this?_____

Type of treatment:_____

Results:_____

Are you pregnant?

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.

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 ❑ 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 understand both the objective and the method that 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 maximal 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.

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

Croixview Family Chiropractic
113 2ND Street
Hudson, WI 54016

Croixview Family Chiropractic--Dr. Jennifer Krohn-Shupe
113 Second Street, Hudson, WI 54016-1503

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Smoking start date (optional): _____
CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

°Option if you reported your medications to us last year:

Have your medications changed since you last reported them to us? Y / N

If Yes, please list regularly used over the counter medications:

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

° I understand that I will be sent an email from this clinic with access to the clinic's online patient portal. This will give me secure access to information about my care.

° Please check out our clinic website at www.croixviewfamilychiropractic.com to discover more about how chiropractic can benefit you in your quest for health and wellness. There are also lots of informative articles on our blog at www.croixviewfamilychiropractic.com/blog

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____