RIVERTOWN CHIROPRACTIC
Let Health Happen

Rivertown Chiropractic | 401 East 2nd Street - Madison, IN 47250 | (812) 273-4325

Adult Member Health Record

ABOUT YOU

Last Name:

First Name/MI | Nickname

Address:

City: | State/Zip Code:

Home Phone: | Cell Phone:

Email Address:

Date of Birth: | Gender:

SS#:

Race: ☐ American Indian ☐ Asian ☐ Alaska Native ☐ Black or African AM ☐ White ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Declined to State

Ethnicity: ☐ Declined to State ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language of choice:

Employer:

Work Phone: | Position/Title:

Marital Status: | Name of Spouse:

HEALTH HABITS

Smoking Status:
☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoker

Do you wear: ☐ heel lifts ☐ sole lifts ☐ inner soles ☐ arch supports

MEDICATIONS

Do you have any allergies to medication? ☐ Yes ☐ No

If Yes, please indicate the following:

Allergy: _____

Reaction: _____

Are you currently taking any medication?

☐ Yes ☐ No

If Yes, please indicate the following:

Medication: _____

CHIROPRACTIC EXPERIENCE

Who referred you to our office?

Have you seen or heard of our office because of (all that apply):
☐ Internet ☐ Website ☐ Sign ☐ Insurance Provider Network ☐ YellowWhite Pages ☐ Other

Have you been adjusted by a chiropractor before? ☐ Yes ☐ No

If yes, when was your last visit to a chiropractor?

Where?

REASON FOR THIS VISIT

Describe the reason for this visit: ☐ Wellness ☐ Condition
If condition, describe:

When did this condition begin and how?

Has this condition: ☐ Gotten worse ☐ Stayed same

Does this concern interfere with:
☐ Work ☐ Sleep ☐ Daily routine

Have you ever had a condition like this or similar? ☐ Yes ☐ No
If yes, when:

Have you seen other doctors for this concern? ☐ Yes ☐ No

Results:

Please describe any additional information or concerns you would like the Doctor to know:

HEALTH PROBLEMS

List any health problems you are currently experiencing:

Revision 10-15-14

ARE YOU AWARE THAT...

The nervous system controls all bodily functions and systems?
☐ Yes ☐ No

Doctors of chiropractic work with the nervous system?
☐ Yes ☐ No

Chiropractic is the largest natural healing profession in the world?
☐ 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.**

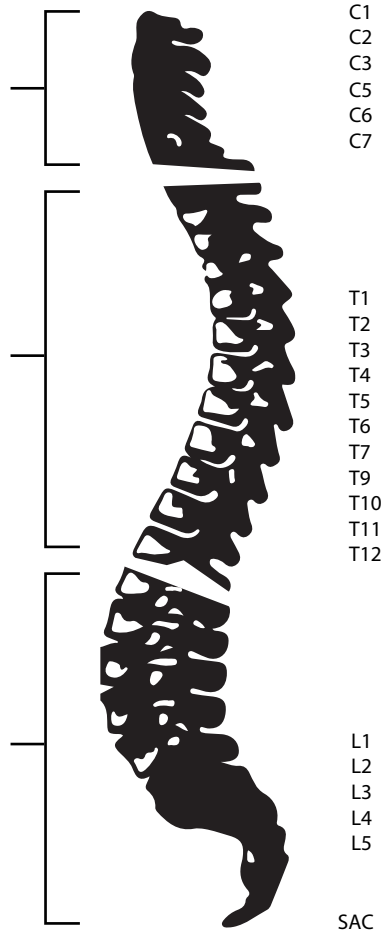
☐ Corrective Care: **Correcting and relieving the cause of the problem as well as the symptom.**

☐ 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 for my condition.**

YOUR CONCERNS

- ☐ *Headaches*
- ☐ *Migraines*
- ☐ *Dizziness*
- ☐ *Sinus Problems*
- ☐ *Fatigue*
- ☐ *Head Colds*
- ☐ *Vision Problems*
- ☐ *Difficulty Concentrating*
- ☐ *Hearing Problems*
- ☐ *Sore Throat*
- ☐ *Stiff Neck*
- ☐ *Radiating Arm Pain*
- ☐ *Hand/Finger Numbness*
- ☐ *Asthma*
- ☐ *Allergies*
- ☐ *High Blood Pressure*
- ☐ *Heart Conditions*
- ☐ *Middle Back Pain*
- ☐ *Congestion*
- ☐ *Difficulty Breathing*
- ☐ *Bronchitis/Pneumonia*
- ☐ *Gallbladder Conditions*
- ☐ *Stomach Problems*
- ☐ *Ulcers*
- ☐ *Gastritis*
- ☐ *Constipation*
- ☐ *Colitis*
- ☐ *Diarrhea*
- ☐ *Irritable Bowel*
- ☐ *Bladder Problems*
- ☐ *Menstrual Problems*
- ☐ *Low Back Pain*
- ☐ *Pain or Numbness in legs*
- ☐ *Reproductive Problems*



HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have had in the past.

☐ severe or frequent headaches	☐ thyroid problems	☐ pain in arms / legs / hands	☐ numbness
☐ heart surgery / pacemaker	☐ sinus problems	☐ low blood pressure	☐ allergies
☐ lower back problems	☐ hepatitis	☐ rheumatic fever	☐ diabetes
☐ digestive problems	☐ difficulty breathing	☐ ulcers/colitis	☐ surgeries
☐ pain between shoulders	☐ kidney problems	☐ tuberculosis	☐ asthma
☐ congenital heart defect	☐ high blood pressure	☐ arthritis	☐ loss of sleep
☐ frequent neck pain	☐ chemotherapy	☐ shingles	☐ dizziness

Are you pregnant? ☐ Yes ☐ No

Sign below to indicate you are NOT pregnant in case x-rays are needed _____

Surgeries: (Please list all surgeries you have had)

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctors of chiropractic who now or in the future work at the office listed above.

I have had an opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which, will be based upon their knowledge and the facts given to them, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of care for my present condition and for any future condition(s) for which I seek chiropractic care.

To be completed by the patient:

_____

Patient Name

_____

Signature of Patient

Date: _____

To be completed by the patient's representative, if necessary, (e.g. if the patient is physically or mentally incapacitated)

_____

Name of Representative

_____

Signature of Patient

Date: _____

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FINANCIAL INFORMATION

I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for all bills incurred at Rivertown Chiropractic, whether or not paid by insurance.

I authorize the use of this signature to allow the insurance companies to pay Rivertown Chiropractic and authorize the doctor to release all information necessary to secure the payment of benefits.

I understand that I may be charged $20 for any missed appointment that I schedule and do not cancel with at least two hours prior notice for the doctor visits and 24 hours prior notice for massage therapist appointments.

Ownership of X-ray Films: It is understood and agreed that the payments to the doctor for x-rays is for the 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.

Sign if read above: _____ 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, public health, research and law enforcement activities.

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 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 and conduct normal healthcare operations. Any other disclosures for the purpose of care, payment or practice operations will be made only after obtaining your consent.

A full copy with a more complete description of the privacy practices of this office can be found on our website at www.rivertownchiro.com or a copy will be provided to you at your request.

I understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (please print): _____

Signature: _____ Date: _____

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