RIVERTOWN CHIROPRACTIC
Let Health Happen

Adult Member Health Record

ABOUT YOU

Last Name:

First Name/MI: | Called Name:

Address:

City: | State/Zip Code:

Home Phone: | Cell Phone:

Email Address:

Date of Birth: | Gender:

SS#:

Race/ Ethnicity:
☐American Indian ☐Asian ☐Alaskan Native
☐Black/African AM ☐White ☐Native Hawaiian
☐Other Pacific Islander ☐Declined to State
☐Hispanic or Latino

Language of choice:

Employer:

Work Phone: | Position/Title:

Marital Status: | Name of Spouse:

Emergency Contact Name/Phone Number

Who referred you to our office?

REASON FOR THIS VISIT

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

When did this condition begin and how?

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 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

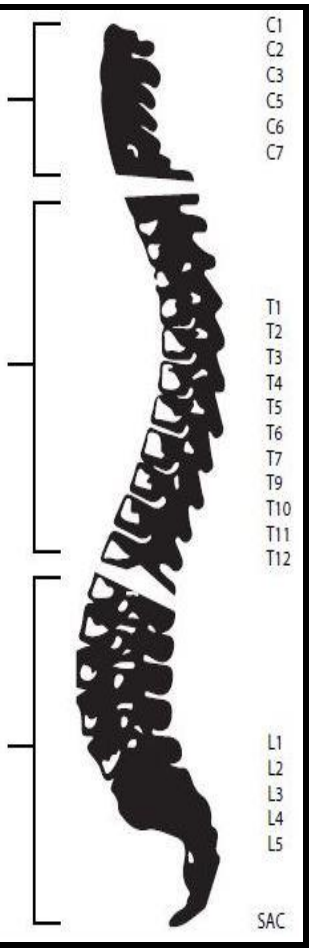
If Yes, please indicate the following:
Medication:

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 PROBLEMS/SURGERIES

List any current health problems or past surgeries:

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 24 hours prior notice for doctor visits and massage therapist appointments.

X-rays: Payment is for digital x-rays and no films will be developed. A disk and/or report are available upon request.

Initials: _____

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.

I understand that a full copy with a more complete description of the privacy practices of this office has been provided to me and I can also find it at www.rivertownchiro.com.

I understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed, and I have been provided with a copy of Rivertown Chiropractic's Patient Privacy Policy.

Initials:_____

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 understand that I will have 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 judgement 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.

In 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 under the age of 18 or physically or mentally incapacitated)

_____
Name of Representative

_____
Signature of Representative or Parent/Guardian

Date: _____