Allen Chiropractic Wellness Center

PATIENT HEALTH RECORD

Account #

ABOUT YOU

NAME	DATE OF BIRTH	AGE
ADDRESS		
CITY	STATE/ZIP CODE	
PHONE 1 HOME / CELL / WORK	PHONE 2 HOME / CELL / WORK	
BEST NUMBER TO REACH YOU? HOME ___ CELL ___ WORK____ MAY WE LEAVE A MESSAGE? ____ CELL CARRIER:_____ MAY WE SEND MONTHLY APPT. TEXT REMINDER_____		
MAY WE EMAIL MONTHLY EDUCATIONAL NEWSLETTER? _____ EMAIL ADDRESS ___		
EMPLOYER NAME	NUMBER	OCCUPATION
SOCIAL SECURITY NUMBER	GENDER	
MARITAL STATUS	PAYMENT METHOD ☐ CASH ☐ CHECK ☐ CREDIT CARD	
SPOUSE NAME	BEST PHONE #	
SPOUSES EMPLOYER	NUMBER	
PRIMARY DOCTOR	PHONE	
LAST VISIT	LAST PHYSICAL	

EMERGENCY CONTACT

NAME	RELATIONSHIP
BEST PHONE #	ALT. PHONE #

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (üALL THAT APPLY) ☐ NEWSPAPER ☐ SIGN ☐ FACEBOOK ☐ 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?

HEALTH HABITS

DO YOU SMOKE? ☐ YES ☐ NO How much per day _____ How many years? _____
ALCOHOL CONSUMPTION - HOW MUCH _____ HOW OFTEN? _____
DO YOU DRINK COFFEE, TEA OR SODA? _____ How much per day_____
DO YOU EXERCISE REGULARLY? ☐ YES - TYPE _____ ☐ NO
DO YOU WEAR ☐ HEEL LIFTS ☐ SOLE LIFTS ☐ INNER SOLES ☐ ARCH SUPPORTS

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO AN ACCIDENT ☐ JOB ☐ SPORTS ☐ AUTO ☐ FALL ☐ HOME INJURY DATE_____ ☐ CHRONIC DISCOMFORT ☐ OTHER PLEASE EXPLAIN
TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT? ☐ AUTO INS ☐ WORKER'S COMP ☐ OTHER
WHEN DID THE SYMPTOMS BEGIN? RATE YOUR WORST PAIN ON A SCALE OF 1-10 ____ ON A GOOD DAY_____ TYPE OF PAIN (mark all that apply) Sharp___ Dull ___ Throbbing ___ Aching ___ Shooting ___ Numb ___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Other__ IS IT CONSTANT _____ INTERMITTENT ____
HAS THIS CONDITION ☐ WORSENED ☐STAYED CONSTANT ☐COME AND GONE
DOES THIS CONDITION INTERFERE WITH ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER ACTIVITIES ACTIVITIES THAT ARE PAINFUL TO PERFORM SITTING ___ STANDING ___ BENDING ___ WALKING ___ LYING ___ OTHE R ___
HAS THIS CONDITION OCCURRED BEFORE? ☐ YES ☐NO PLEASE EXPLAIN
WHO HAVE YOU SEEN FOR THIS CONDITION? DOCTOR'S NAME NAME PHONE ADDRESS
TYPE OF TESTS MRI ____ X-RAY ___ TREATMENT Meds ___ Surgery ___ Phys. Therapy ___ Chiropractic ___
RESULTS WHERE WAS IT DONE

NAME _____

ALLERGIES

ENVIRONMENTAL / FOOD / MEDICATIONS

SURGERIES

MEDICATIONS / SUPPLEMENTS

YOUR CONCERNS

***INSTRUCTIONS Place an** X by the concerns or conditions you may be experiencing **NOW.** Each area of concern relates to an area of the spine and nerve function.*

Sore throat ___
Stiff neck ___
Radiating arm pain ___
Hand / Finger ___
Numbness ___
Asthma ___
Allergies ___
Blood pressure ___
Heart conditions ___
Thyroid ___

Mid Back ___
Congestion ___
Breathing ___
Bronchitis ___
Pneumonia ___
Gallbladder ___
Stomach ___
Ulcers ___
Gastritis ___
Kidney ___

Constipation ___
Colitis ___
Diarrhea ___
Gas pain ___
Irritable bowel ___
Bladder ___
Menstrual issues ___
Low back pain ___
Leg pain ___
Numbness in legs ___
Reproductive ___

Headaches ___
Migraines ___
Dizziness ___
Sinus ___
Allergies ___
Fatigue ___
Head colds ___
Vision ___
Difficulty Concentrating ___
Hearing ___
Jaw ___

OTHER

_____
_____
_____
_____
_____
_____
_____
_____
_____

HEALTH HISTORY

***Check and LIST WHO IT APPLIES TO:** Do **you** or your **family members have—or had in the past,** any of the following: (While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and care plan.)*

- ❑ SEVERE OR FREQUENT HEADACHES
- ❑ EPILEPSY
- ❑ DIZZINESS /TINNITIS
- ❑ ANXIETY
- ❑ SHINGLES
- ❑ ARTHRITIS
- ❑ TUBERCULOSIS
- ❑ A-FIB
- ❑ STROKE
- ❑ HEART ATTACK
- ❑ PACEMAKER
- ❑ HIGH BLOOD PRESSURE
- ❑ CONGENITAL HEART DEFECT
- ❑ RHEUMATIC FEVER
- ❑ CANCER
- ❑ DIABETES
- ❑ THYROID PROBLEMS
- ❑ ASTHMA / BRONCHITIS
- ❑ DIGESTIVE PROBLEMS
- ❑ ULCERS/COLITIS
- ❑ KIDNEY PROBLEMS
- ❑ URINARY PROBLEMS
- ❑ HIV / AIDS
- ❑ HEPATITIS
- ❑ LOWER BACK PROBLEMS
- ❑ FREQUENT NECK PAIN
- ❑ PAIN BETWEEN SHOULDERS
- ❑ DIFFICULTY BREATHING
- ❑ SLEEP PROBLEMS
- ❑ SINUS PROBLEMS
- ❑ OTHER:

FOR WOMEN ONLY

PREGNANT? _____
DUE DATE? _____

NURSING? _____
ARE YOU TAKING BIRTH CONTROL? _____
HAVE HORMONE IMPLANTS? _____
HAVE PAINFUL PERIODS? ____

HAVE IREEGULAR CYCLES? ☐ YES ☐NO

HAVE BREAST IMPLANTS ☐ YES ☐NO

ALLEN CHIROPRACTIC WELLNESS CENTER
1018 S WESTWOOD BLVD STE 5, POPLAR BLUFF, MO 63901
573-778-0500 HIPAA FAX 888-972-7541

NAME _____

DOB _____

AUTHORIZATION FOR CARE

I hereby authorize Dr Allen to work with my condition using recommended protocols as 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 at time of service. 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.

SIGNATURE	DATE
GUARDIAN OR SPOUSE AUTHORIZING CARE 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

NO SHOW FEE

Your health care is very important to us. ***We expect you to keep scheduled appointments.***

- *Late arrival may require your appointment to be rescheduled.*
- *Should you need to reschedule, however, please call our office 24 HOURS in advance to* ***avoid being charged our regular office fee.***
- *Please understand that someone else in pain may need that time. We appreciate your cooperation in this matter.*
- *We manage our schedule to keep you and others from waiting a long time.*

SIGNATURE	DATE
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE	DATE