

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
HOME PHONE:	CELL PHONE:	
EMAIL ADDRESS:		
DATE OF BIRTH:	AGE:	GENDER
MARITAL STATUS:	# OF CHILDREN:	
HOW DID YOU HEAR ABOUT OWC?		
EMPLOYER NAME:		
WORK PHONE:	POSITION TITLE:	

REASON FOR THIS VISIT

Please list your 3 main health concerns in order of importance.

- 1.
- 2.
- 3.

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

WELLNESS DIGESTIVE DISCOMFORT HORMONE ISSUES
 FATIGUE WEIGHT LOSS NUTRITIONAL EVAL
 DEPRESSION/ANXIETY INSOMNIA/SLEEP ISSUES ADD/ADHD
 SEIZURES STRESS ACCIDENT PAIN

PLEASE EXPLAIN:

WHEN DID THIS CONDITION BEGIN?

HOW FREQUENTLY DO YOUR SYMPTOMS OCCUR?

CONSTANT FREQUENT INTERMITTENT OCCASIONAL

DOES THIS CONDITION INTERFERE WITH:

WORK SLEEP DAILY ROUTINE HOME LIFE

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE? NO YES

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?

NO YES, Whom? _____

TYPE OF TREATMENT:

RESULTS:

IF YOU KNEW CHIROPRACTIC COULD BENEFIT YOU, WOULD YOU BE INTERESTED IN LEARNING MORE?

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?

DATE OF LAST VISIT: DOCTOR'S NAME:

GOALS FOR YOUR CARE

People see us for a variety of reasons—relief of pain, enhance a child's growth potential, and many for overall wellness & preventative care. We will weigh your needs & desires when recommending your care program. Please check the type of care you desire.

- 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.
- I want the Doctor to select the type of care appropriate for my condition.**

YOUR INTERESTS...

INSTRUCTIONS: Please check all items that you may be interested in.

<input type="checkbox"/> WELLNESS TESTING	<input type="checkbox"/> WELLNESS PROGRAM	<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> HORMONE TESTING	<input type="checkbox"/> NEUROTRANSMITTER TESTING
<input type="checkbox"/> FOOD SENSITIVITIES	<input type="checkbox"/> HEAVY METAL TESTING	<input type="checkbox"/> CLEANSING DETOX	<input type="checkbox"/> VITAMINS SUPPLEMENTS	<input type="checkbox"/> NUTRITIONAL COUNSELING
<input type="checkbox"/> CHIROPRACTIC	<input type="checkbox"/> MEDITATION	<input type="checkbox"/> MASSAGE THERAPY	<input type="checkbox"/> REIKI	<input type="checkbox"/> HEALTHY COOKING CLASSES
<input type="checkbox"/> YOGA	<input type="checkbox"/> COLD LASER THERAPY	<input type="checkbox"/> KINESIOTAPING	<input type="checkbox"/> DECOMPRESSION	<input type="checkbox"/> HEALTHY LIVING WORKSHOPS

Optimal Wellness Center
A Creating Wellness Center



LIFESTYLE HEALTH HABITS

EXERCISE & SLEEP HABITS

INSTRUCTIONS: Please check all that apply to your normal lifestyle routine.

- | | |
|---|------------|
| <input type="checkbox"/> FLEXIBILITY / STRETCHING | How often? |
| <input type="checkbox"/> STRENGTH / RESISTING TRAINING | How often? |
| <input type="checkbox"/> CARDIO EXERCISE | How often? |
| <input type="checkbox"/> SIT FOR MORE THAN 8 HRS A DAY | |
| <input type="checkbox"/> SLEEP FOR LESS THAN 8 HRS A NIGHT (uninterrupted) | |
| <input type="checkbox"/> SATISFIED WITH CURRENT LEVEL OF EXERCISE & ROUTINE | |
| <input type="checkbox"/> LOOKING FOR A DIFFERENT ROUTINE OR MORE COACHING | |

DIETARY HABITS

INSTRUCTIONS: Please check each item that you eat, drink or use regularly:

- | | | |
|---|---|--|
| <input type="checkbox"/> ALCOHOL | <input type="checkbox"/> FAST FOOD REGULARLY | <input type="checkbox"/> MILK PRODUCTS |
| <input type="checkbox"/> CHEW TOBACCO | <input type="checkbox"/> FRIED FOODS | <input type="checkbox"/> CANDY |
| <input type="checkbox"/> CARBONATED BEVERAGES | <input type="checkbox"/> REFINED (WHITE) FLOUR PRODUCTS | <input type="checkbox"/> ARTIFICIAL SWEETENERS |
| <input type="checkbox"/> CIGARETTES | <input type="checkbox"/> LUNCH MEATS | <input type="checkbox"/> DISTILLED WATER |
| <input type="checkbox"/> COFFEE | <input type="checkbox"/> MARGARINE | <input type="checkbox"/> FRESH VEGGIES |
| <input type="checkbox"/> NON-HERBAL TEAS | <input type="checkbox"/> NON-ORGANIC MEAT | <input type="checkbox"/> FRESH FRUITS |
| <input type="checkbox"/> TAP WATER | <input type="checkbox"/> REFINED SUGARS | <input type="checkbox"/> VITAMINS/SUPPLEMENTS |

HEALTH CONDITIONS

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

- | | | |
|--|--|--|
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PAIN BETWEEN SHOULDERS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART SURGERY/PACEMAKER | <input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> LOSS OF SLEEP | <input type="checkbox"/> SHINGLES |
| <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> LOWER BACK PROBLEMS | <input type="checkbox"/> SURGERIES: |
| <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> HEADACHES/MIGRAINES | <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> ULCERS/COLITIS |

YOUR CONCERNS

INSTRUCTIONS: Please **circle** the health concerns or conditions you may be experiencing now or have in the past. Each area of concern relates to proper nerve function.

Sore Throat
Thyroid Dysfunction
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
High Blood Pressure
Heart Conditions
Cholesterol Issues



Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Ear Aches/Infections
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:

MEDICATIONS

INSTRUCTIONS: Please check each of the medications that you are currently taking (or took for many years). Next to the item, please write the number of months or years on the medication.

- | | | |
|---|--|---|
| <input type="checkbox"/> ANTACIDS | <input type="checkbox"/> DIURETICS | <input type="checkbox"/> RADIATION |
| <input type="checkbox"/> ANTIBIOTIC/ANTI-FUNGAL | <input type="checkbox"/> HEART MEDICATIONS | <input type="checkbox"/> RELAXANTS |
| <input type="checkbox"/> ANTIDEPRESSANTS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SLEEPING PILLS |
| <input type="checkbox"/> ANTI-DIABETIC/INSULIN | <input type="checkbox"/> HORMONES | <input type="checkbox"/> RECREATIONAL DRUGS |
| <input type="checkbox"/> ASPIRIN/TYLENOL | <input type="checkbox"/> LAXATIVES | <input type="checkbox"/> THYROID |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> LITHIUM | <input type="checkbox"/> ULCER MEDS |
| <input type="checkbox"/> CORTISON ANTI-INFLAMMATORIES | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OTHER: |

AUTHORIZATIONS & RELEASES

TERMS OF ACCEPTANCE

When a patient seeks holistic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Our office 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. I will alert the doctor and/or a staff member if I do not understand or accept part of treatment.

I hereby authorize the Doctor to work with my condition through the use of nutritional supplements, chiropractic adjustments, massages, exercises and/or therapies, 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.

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.

SIGNATURE:

DATE:

PATIENT HISTORY and GOALS

FOR OFFICE USE ONLY

CONERNS ABOUT SYMPTOMS:

ANYONE ELSE IN FAMILY HAD THESE SYMPTOMS?

IS CURRENT HEALTH STATUS INTERFERING W/ LIFE, WORK, FAMILY, ETC?

THINGS YOU WISH YOU COULD DO (OR DO BETTER) IF YOU HAD GREATER HEALTH?

HEALTHIER NOW OR 5 YRS AGO?

WHAT HAVE YOU DONE DIFFERENTLY?

WHAT COULD YOU DO DIFFERENTLY?

ARE YOU WILLING TO DO THESE THINGS?

IS YOUR HEALTH IMPORTANT TO YOU?