

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:		DATE:	
ADDRESS:			
CITY:		STATE/ ZIP CODE:	
HOME PHONE:		CELL PHONE:	
EMAIL ADDRESS:			
BEST CONTACT METHOD- CIRCLE HOME PH CELL PH WORK PH EMAIL TEXT			
DATE OF BIRTH:		AGE:	
SOCIAL SECURITY NUMBER:		NAME & AGES OF CHILDREN:	
MARITAL STATUS:			
EMPLOYER NAME:			
EMPLOYER ADDRESS:			
EMPLOYER CITY:		EMPLOYER STATE ZIP CODE:	
WORK PHONE:		POSITION TITLE:	
INSURANCE COMPANY:			
INSURED'S NAME :			
INSURED'S SOCIAL SECURITY NUMBER:			
INSURED'S DATE OF BIRTH:			

ABOUT YOUR SPOUSE

SPOUSE NAME:	
SPOUSE EMPLOYER:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
POSITION TITLE:	

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): NEWSPAPER SIGN YELLOW PAGES COMMUNITY EVENT MAILING INSURANCE
NAME OF PRIMARY CARE PHYSICIAN:
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? YES NO
DOCTOR'S NAME: APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR? YES NO

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

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

MEDICATIONS YOU TAKE

Please List All Medications You Take:

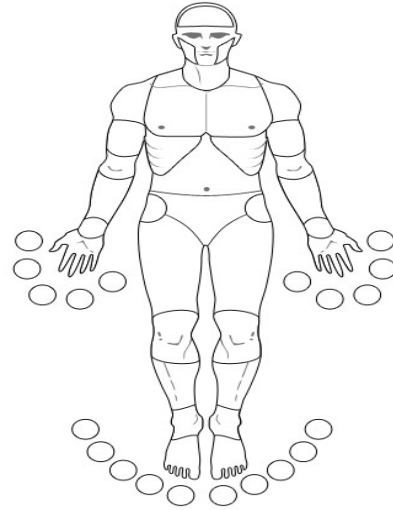
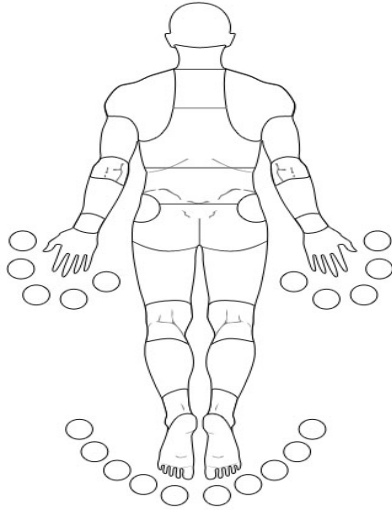
Please List All Vitamins and Supplements You Take:

Name: _____

Date: _____

- Headaches
- Neck
- Upper back
- Mid Back
- Lower Back
- Hip
- Buttock
- Shoulder
- Arm
- Elbow
- Forearm
- Wrist
- Hand
- Fingers
- Leg
- Knee
- Calf
- Shin
- Ankle
- Foot
- Toes
- Chest

Please CIRCLE the current complaints you are experiencing in the LEFT hand column and MARK the areas on the image BELOW, providing details using the sections that follow



CONCERN AREA #1
PAIN IS LOCATED? <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BOTH <input type="checkbox"/> CENTER
WHAT IS THE PAIN RATING? CIRCLE NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN
IS YOUR CURRENT COMPLAINT: <input type="checkbox"/> INFREQUENT <25% <input type="checkbox"/> OCCASIONAL 25% to 50% <input type="checkbox"/> FREQUENT 50% to 75% <input type="checkbox"/> CONSTANT > 75%
WHEN AND HOW DID IT START?
TIMING <input type="checkbox"/> MORNING <input type="checkbox"/> AFTERNOON <input type="checkbox"/> DURING NIGHT <input type="checkbox"/> EVENING <input type="checkbox"/> LIGHT ACTIVITIES <input type="checkbox"/> MODERATE ACTIVITIES
IS YOUR PAIN: <input type="checkbox"/> ACHING <input type="checkbox"/> DULL <input type="checkbox"/> SHARP <input type="checkbox"/> STABBING <input type="checkbox"/> THROBBING <input type="checkbox"/> ELECTRIC <input type="checkbox"/> BURNING <input type="checkbox"/> SHOOTING <input type="checkbox"/> DEEP <input type="checkbox"/> SUPERFICIAL
DOES THE PAIN RADIATE TO OTHER AREAS, IF SO, WHERE?
WHAT MAKES THE PAIN FEEL BETTER? <input type="checkbox"/> MEDICATION <input type="checkbox"/> LYING DOWN <input type="checkbox"/> STANDING <input type="checkbox"/> SITTING <input type="checkbox"/> STRETCHING <input type="checkbox"/> MOVEMENT <input type="checkbox"/> ICE <input type="checkbox"/> HEAT <input type="checkbox"/> NOTHING
OTHER
WHAT MAKES THE PAIN FEEL WORSE? <input type="checkbox"/> MOVEMENTS <input type="checkbox"/> BENDING <input type="checkbox"/> TWISTING <input type="checkbox"/> WEIGHT BEARING <input type="checkbox"/> SNEEZING <input type="checkbox"/> SITTING <input type="checkbox"/> STANDING <input type="checkbox"/> WALKING <input type="checkbox"/> CHEWING <input type="checkbox"/> YAWNING <input type="checkbox"/> PUSHING/PULLING <input type="checkbox"/> LIFTING <input type="checkbox"/> WATCHING TV <input type="checkbox"/> READING <input type="checkbox"/> WORKING <input type="checkbox"/> DRIVING <input type="checkbox"/> HOUSEWORK <input type="checkbox"/> BRIGHT LIGHTS <input type="checkbox"/> LYING DOWN OTHER
WHAT SIDE EFFECTS DO YOU HAVE? <input type="checkbox"/> HEADACHES <input type="checkbox"/> DECREASED MOVEMENT <input type="checkbox"/> INCREASED SENSITIVITY <input type="checkbox"/> NUMBNESS <input type="checkbox"/> STIFFNESS <input type="checkbox"/> TIGHTNESS <input type="checkbox"/> TINGLING
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
COMMENTS:

CONCERN AREA #2
PAIN IS LOCATED? <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BOTH <input type="checkbox"/> CENTER
WHAT IS THE PAIN RATING? CIRCLE NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN
IS YOUR CURRENT COMPLAINT: <input type="checkbox"/> INFREQUENT <25% <input type="checkbox"/> OCCASIONAL 25% to 50% <input type="checkbox"/> FREQUENT 50% to 75% <input type="checkbox"/> CONSTANT > 75%
WHEN AND HOW DID IT START?
TIMING <input type="checkbox"/> MORNING <input type="checkbox"/> AFTERNOON <input type="checkbox"/> DURING NIGHT <input type="checkbox"/> EVENING <input type="checkbox"/> LIGHT ACTIVITIES <input type="checkbox"/> MODERATE ACTIVITIES
IS YOUR PAIN: <input type="checkbox"/> ACHING <input type="checkbox"/> DULL <input type="checkbox"/> SHARP <input type="checkbox"/> STABBING <input type="checkbox"/> THROBBING <input type="checkbox"/> ELECTRIC <input type="checkbox"/> BURNING <input type="checkbox"/> SHOOTING <input type="checkbox"/> DEEP <input type="checkbox"/> SUPERFICIAL
DOES THE PAIN RADIATE TO OTHER AREAS, IF SO, WHERE?
WHAT MAKES THE PAIN FEEL BETTER? <input type="checkbox"/> MEDICATION <input type="checkbox"/> LYING DOWN <input type="checkbox"/> STANDING <input type="checkbox"/> SITTING <input type="checkbox"/> STRETCHING <input type="checkbox"/> MOVEMENT <input type="checkbox"/> ICE <input type="checkbox"/> HEAT <input type="checkbox"/> NOTHING
OTHER
WHAT MAKES THE PAIN FEEL WORSE? <input type="checkbox"/> MOVEMENTS <input type="checkbox"/> BENDING <input type="checkbox"/> TWISTING <input type="checkbox"/> WEIGHT BEARING <input type="checkbox"/> SNEEZING <input type="checkbox"/> SITTING <input type="checkbox"/> STANDING <input type="checkbox"/> WALKING <input type="checkbox"/> CHEWING <input type="checkbox"/> YAWNING <input type="checkbox"/> PUSHING/PULLING <input type="checkbox"/> LIFTING <input type="checkbox"/> WATCHING TV <input type="checkbox"/> READING <input type="checkbox"/> WORKING <input type="checkbox"/> DRIVING <input type="checkbox"/> HOUSEWORK <input type="checkbox"/> BRIGHT LIGHTS <input type="checkbox"/> LYING DOWN OTHER
WHAT SIDE EFFECTS DO YOU HAVE? <input type="checkbox"/> HEADACHES <input type="checkbox"/> DECREASED MOVEMENT <input type="checkbox"/> INCREASED SENSITIVITY <input type="checkbox"/> NUMBNESS <input type="checkbox"/> STIFFNESS <input type="checkbox"/> TIGHTNESS <input type="checkbox"/> TINGLING
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
COMMENTS:

NAME:

PRIOR HISTORY

Have you had any child or adult illnesses?
Have you had any serious falls as a child or adult?
Did you or do you play sports or other physical activity?
Did you take Medications? If yes, please list. Child: Adult:
Have you had any surgeries?
Have you fallen / jumped from a height over three feet?
Were you in any car accidents as a child or adult? When?
Did you suffer any other traumas (physical or emotional)?

FAMILY HISTORY

INSTRUCTIONS:
Please check each box below the illness if it affected a person in your family. **SB**= sister or brother **P**= parent

HEADACHES <input type="checkbox"/> SB <input type="checkbox"/> P	CIRRHOSIS/ HEPATITIS <input type="checkbox"/> SB <input type="checkbox"/> P	KIDNEY TROUBLE <input type="checkbox"/> SB <input type="checkbox"/> P	SINUS TROUBLE <input type="checkbox"/> SB <input type="checkbox"/> P
ALLERGIES <input type="checkbox"/> SB <input type="checkbox"/> P	TUBERCULOSIS <input type="checkbox"/> SB <input type="checkbox"/> P	BACK PROBLEMS <input type="checkbox"/> SB <input type="checkbox"/> P	EPILEPSY <input type="checkbox"/> SB <input type="checkbox"/> P
ANEMIA <input type="checkbox"/> SB <input type="checkbox"/> P	DISLOCATED JOINTS <input type="checkbox"/> SB <input type="checkbox"/> P	LOW BLOOD PRESSURE <input type="checkbox"/> SB <input type="checkbox"/> P	THYROID TROUBLE <input type="checkbox"/> SB <input type="checkbox"/> P
ARTHRITIS <input type="checkbox"/> SB <input type="checkbox"/> P	MULTIPLE SCLEROSIS <input type="checkbox"/> SB <input type="checkbox"/> P	MENTAL/ EMOTIONAL DIFFICULTY <input type="checkbox"/> SB <input type="checkbox"/> P	DIABETES <input type="checkbox"/> SB <input type="checkbox"/> P
ASTHMA <input type="checkbox"/> SB <input type="checkbox"/> P	HEART PROBLEM <input type="checkbox"/> SB <input type="checkbox"/> P	PROSTATE TROUBLE <input type="checkbox"/> SB <input type="checkbox"/> P	ULCER <input type="checkbox"/> SB <input type="checkbox"/> P
CANCER <input type="checkbox"/> SB <input type="checkbox"/> P	REPRODUCTIVE <input type="checkbox"/> SB <input type="checkbox"/> P	RHEUMATIC FEVER <input type="checkbox"/> SB <input type="checkbox"/> P	EAR PROBLEMS <input type="checkbox"/> SB <input type="checkbox"/> P
BONE FRACTURE <input type="checkbox"/> SB <input type="checkbox"/> P	HIGH BLOOD PRESSURE <input type="checkbox"/> SB <input type="checkbox"/> P	ADD/ADHD <input type="checkbox"/> SB <input type="checkbox"/> P	SCOLIOSIS <input type="checkbox"/> SB <input type="checkbox"/> P
OTHER:			

YOUR CONCERNS NOW

INSTRUCTIONS: Please **circle** the health concerns or conditions you may be experiencing **now**. Each area of concern relates to an area of the spine and nerve function.

- TMJ Issues
- Sore Throat
- Stiff Neck
- Radiating Arm Pain
- Hand/Finger Numbness
- Asthma
- Thyroid Issues
- High Blood Pressure
- Low Blood Pressure
- Heart Conditions



- C1 Headaches
- C2 Migraines
- C3 Dizziness
- C4 Sinus Problems
- C5 Allergies
- C6 Fatigue
- C7 Head Colds
- T1 Vision Problems
- T2 Hearing Problems
- T3 Difficulty Concentrating

- T4 Middle Back Pain
- T5 Shoulder Problems
- T6 Congestion
- T7 Difficulty Breathing
- T8 Bronchitis
- T9 Pneumonia
- T10 Gallbladder Conditions
- T11 Heartburn
- T12 Ulcers
- OTHER: Gastritis
- Kidney Stones

- L1 Constipation
- L2 Colitis
- L3 Diarrhea
- L4 Gas Pain
- L5 Irritable Bowel
- S Bladder Problems
- A Infertility
- C Prostate Issues
- R Menstrual Problems
- A Hip Disorders
- L Low Back Pain
- Pain or Numbness in

- OTHER: Osteoporosis
- Arthritis
- Scoliosis
- Anxiety
- Depression
- Acne
- Hair Loss
- Rash
- Immune Disorders
- Low Libido
- Sudden Weight Change
- Diabetes



The NeuroSpinal Function Index rates your overall health.

Please mark an "X" where you believe your health is and an "O" where you would like to be.

Health History

INSTRUCTIONS: Please check each of the diseases or conditions that **you have had in the past**. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/ LEGS/HANDS	<input type="checkbox"/> CANCER	FOR WOMEN ONLY:
<input type="checkbox"/> HEART SURGERY/ PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> HIGH BLOOD PRESSURE	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO I declare at this time, to the best of my knowledge, that I am not pregnant and Dr. Taylor and associates have my permission to perform X-Ray evaluation.
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPTATIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFUCLTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> ALLERGIES	ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SURGERY- PLEASE LIST	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	DO YOU: EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> KIDNEY ISSUES	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> OTHER	

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:

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 statements on your account?

PATIENT SPOUSE PARENT 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: