STUDER CHIROPRACTIC P.C.

It is our pleasure to be of service to you. Please fill out our confidential Patient Health Record completely and accurately.

Studer Chiropractic is dedicated to removing nerve interference by hand to restore and maintain optimum health.

Through education we promote a lifetime of health, strength, and vitality.

We envision chiropractic care for every man, woman and child to build a healthier community and world.

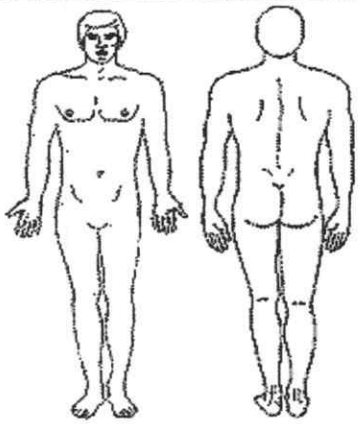
ADULT HISTORY

ABOUT THE PATIENT

Name_____ Birth Date _____
Address_____ City_____State___Zip_____
Phone: H_____ C _____ W_____
Employer_____ Type of work_____
Marital Status ☐Mar. ☐Sing. ☐Div ☐Wid. Spouse's name_____
Children's names and ages _____
_____
Email Address_____
Would you like us to email you our monthly newsletter? ☐ Yes ☐No

REASON FOR THIS VISIT

Describe the purpose of this visit_____
_____
Is the purpose of this appointment related to ☐ Job ☐ Auto ☐ Fall
☐ Sports ☐ Daily Life ☐ Chronic Discomfort ☐ Other
When did this health challenge begin? _____
Does this interfere with ☐ Work ☐ Sleep ☐ Daily Routine
☐ Other Activities Explain _____
Using the diagram to the right please indicate with an X where your problems are occurring
Have you seen other professionals for this? ☐ Yes ☐ No
Dr.'s Name (s) _____
Type of Treatment _____
Results



_____
What are your objectives in consulting us? _____
What are your health goals once these objectives have been met? _____
_____
What other wellness professionals are currently a part of your health care team?
☐ Massage therapist ☐ Acupuncturist ☐ Naturopath ☐ Homeopath ☐ Other _____

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
- ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ☐ Yes ☐ No

GOALS FOR MY CARE

Which best describes your reason for consulting our office?

☐ I am only concerned about relief of a particular symptom.
☐ I am only concerned about relief of a particular symptom, and preventing its return.
☐ I want optimum health and wellbeing on every level available to me.

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office?_____
Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No
Reason for those visits?_____
Previous Chiropractor's Name _____
Approximate Date of Last Visit _____
Approximate Date of Last X-ray _____
Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No
Has any child in your family seen a Chiropractor? ☐ Yes ☐ No

MEDICATIONS I NOW TAKE

☐ Stomach Medications
☐ Pain Killers (including aspirin)
☐ Muscle Relaxers
☐ Blood Pressure
☐ Insulin
☐ Stimulants
☐ Blood Thinners
☐ Anxiety/depression
☐ Hormone Therapy
☐ Cholesterol
☐ _____

HEALTH HABITS

Do you....	**No**	**Yes (please explain)**
Smoke?	☐	☐ ____ packs/day
Drink alcohol?	☐	☐ ____ drinks/week
Drink coffee/soda?	☐	☐ ____/day
Exercise regularly?	☐	☐ _____
Take any supplements?	☐	☐ _____
		_____

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has 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.

☐ Headaches
☐ Allergies
☐ Sinus problems
☐ Dizziness
☐ Loss of sleep
☐ Pain between the shoulders
☐ Frequent neck pain
☐ Numbness or pain in arms/legs/hands
☐ Lower back problems
☐ Digestive problems
☐ Ulcers/colitis
☐ Low energy
☐ Heart surgery/ pacemaker
☐ Heart murmur
☐ High/low blood pressure
☐ Difficulty breathing
☐ Asthma
☐ Arthritis
☐ Alcohol/drug abuse
☐ Lowered immune system
☐ Diabetes
☐ Irregular Bowel
☐ Shingles
☐ Kidney problems
☐ Hepatitis
☐ Cancer
☐ Chemotherapy
☐ Anemia
☐ Anxiety/Depression
☐ Thyroid problems
☐ Heart attack
☐ Carpal Tunnel
☐ Fibromyalgia
☐ Other _____
_____

For Women:
Are you pregnant? ☐Yes ☐No
Are you nursing? ☐Yes ☐No
Are you taking birth control pills? ☐Yes ☐No
Do you experience painful periods? ☐Yes ☐No
Do you have irregular cycles? ☐Yes ☐No

Are you healthier now than you were 5 years ago? ☐ Yes ☐ No If yes, what did you do to accomplish this?
_____
If no, why do you think your health has deteriorated over the last 5 years? _____
_____

Will you be healthier 5 years from now than you are today? ☐ Yes ☐ No
Why or why not? _____
What would you like your health to be 5 years from now? _____
How many Medical Doctor's office visits did you and your family have last year?
☐ None ☐ Less than 5 ☐ More than 5 ☐ More than 10 ☐ More than 20 ☐ Too many

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of **vertebral subluxations**. Stress that may be physical, chemical or emotional may cause these **subluxations**. The practice of chiropractic is based on the location and reduction of nerve system interference caused by the **vertebral subluxations**.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following.

PLEASE TELL US ABOUT ANY STRESS RELATED TO YOUR BIRTH:

	No	Yes	Explain:
• Drugs/medicine/tobacco/alcohol in pregnancy?	☐	☐	_____
• Labor chemically induced?	☐	☐	_____
• Forceps/Vacuum Extraction/C-section?	☐	☐	_____
• Premature delivery?	☐	☐	_____
• Vaccinations?	☐	☐	_____
• Falls in first year of life?	☐	☐	_____
• Any health related problems?	☐	☐	_____

PLEASE TELL US ABOUT ANY STRESS DURING YOUR CHILDHOOD:

	No	Yes	Explain:
• Any falls or injuries?	☐	☐	_____
• Allergy/Asthma or Respiratory problems?	☐	☐	_____
• Ear Infections?	☐	☐	_____
• Digestive Problems?	☐	☐	_____
• Hyperactivity?	☐	☐	_____
• Any other health related problems?	☐	☐	_____

PLEASE TELL US ABOUT ANY STRESS UP TO THE PRESENT:

	No	Yes	Explain:
• Auto Injuries?	☐	☐	_____
• Work Injuries?	☐	☐	_____
• Sports Injuries?	☐	☐	_____
• Work Stress?	☐	☐	_____
• Family/Home Stress?	☐	☐	_____
• Prescription Drug Use?	☐	☐	_____
• Ever Hospitalized/Surgeries?	☐	☐	_____
• Recurring Illnesses?	☐	☐	_____
• Limited Exercise?	☐	☐	_____
• Poor Nutrition?	☐	☐	_____
• Other Health Issues?	☐	☐	_____

AUTHORIZATION FOR CARE

I hereby authorize Studer Chiropractic P.C. and its Doctors to administer care as they deem necessary. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. 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 Studer Chiropractic P.C. will be credited to my account on receipt.

Patient or Guardian Signature: _____ Date: _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records for a fee at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Signature Date

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that 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 among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

Patient
Signature
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- o **Individual refused to sign**
- o **Communications barriers prohibited obtaining the Acknowledgment**

An emergency situation prevented us from obtaining Acknowledgment

Other (Please Specify) _____

_____

_____

Staff signature **Date**