

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	GENDER:
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	

ABOUT YOUR SPOUSE

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

HEALTH HABITS

DO YOU SMOKE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per day _____
DO YOU DRINK ALCOHOL?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much per week _____
DO YOU DRINK COFFEE, TEA, OR SODA		If yes, how much per day _____
DO YOU EXERCISE REGULARLY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU WEAR:		
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS		

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): <input type="checkbox"/> FACEBOOK <input type="checkbox"/> STREET SIGN <input type="checkbox"/> FAMILY <input type="checkbox"/> FRIEND <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> GOOGLE
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> 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?

PROBLEM AREAS

INSTRUCTIONS: Please mark the area and type of pain on drawings using the codes listed below:

N = Numbness

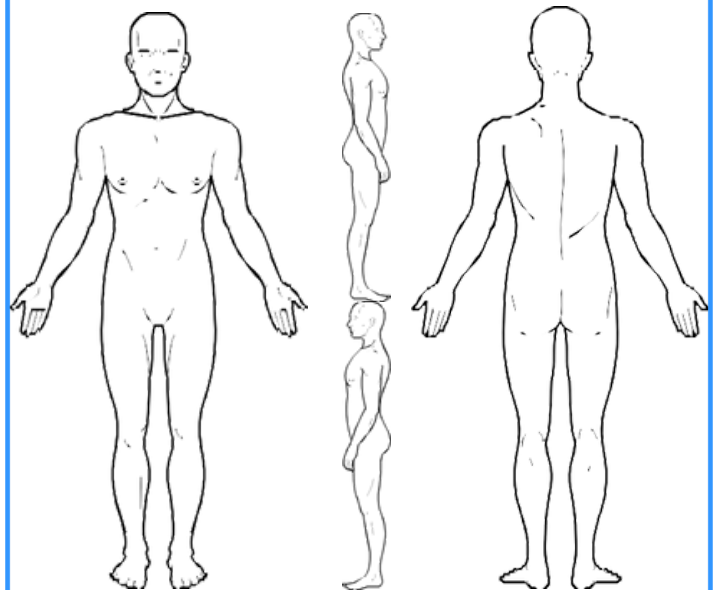
T = Tingling

P = Pain

A = Ache

St = Stiffness

So = Soreness



BENDER
CHIROPRACTIC
HEALTH & VITALITY CENTER
INTEGRATING NUTRITION & CHIROPRACTIC CARE
— HOLISTIC WELLNESS —

33580 Harper Ave
Clinton Township, MI 48035
586 – 296 – 6242

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 with Chiropractic care.
- ☐ I want the Doctor to select the appropriate type of care

MEDICATIONS YOU TAKE

☐ CHOLESTEROL MEDICATIONS ☐ BLOOD PRESSURE MEDICINE

☐ STIMULANTS ☐ BLOOD THINNERS

☐ TRANQUILIZERS ☐ PAIN KILLERS (INCLUDING ASPIRIN)

☐ MUSCLE RELAXERS ☐ OTHER:

☐ INSULIN ☐ OTHER:

☐ VITAMINS & SUPPLEMENTS:

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 an area of the spine and nerve function.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

C5
C6
C7
T1

C1 Headaches
Migraines
Dizziness
C3 Sinus Problems
C4 Allergies

Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

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

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

L1
L2
L3
L4
L5
S
A
C
R
A
L

OTHER:

HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or 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"/> NUMBNESS	FOR WOMEN ONLY:
<input type="checkbox"/> HEART SURGERY/ PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	ARE YOU NURSING? <input checked="" 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"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<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"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	

PATIENT CASE HISTORY

CHIEF CONCERNS:

When did this happen?	How did this happen? (circle answer) Yes : Filed a workers comp. claim Yes / No Other : Accident: Filed insurance claim	Have you had this condition before?
Is your condition getting: (circle answer) Better / Worse / Staying the same	Does the pain travel or radiate anywhere?	Severity of pain: 0 (no pain) – 10 (call an ambulance) Pain level when it first happened: _____ Today's pain level: _____ Pain level at best: _____ at worst: _____
When do you have your pain? Is it worse during certain times of day?	Does this condition interfere with any activities of daily living? (sleeping, bathing, dressing, taking care of yourself) <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	What makes it feel worse?
What makes it feel better?	Is there anything you want to do but can't or are limited doing because of this condition? (sports, travel, hobbies, etc.)	What have you done for this condition so far?

CIRCLE ANY OF THE FOLLOWING SYMPTOMS (INCLUDING REPEAT ANSWERS)

<u>NEUROLOGICAL</u> Numbness / Tingling / Weakness Coldness / Color Change Headaches / Dizziness Pain upon Coughing, Sneezing, or Straining Loss of Bowel or Bladder Control	<u>INFECTION</u> Fever / Chills / Fatigue / Sweating Anorexia	<u>NEOPLASTIC</u> Night Pain Night Sweats Unexpected Weight Loss Deep Boring Bone Pain
<u>METABOLIC</u> Increased: Thirst / Hunger / Urination Temperature Intolerance Unexpected Weight Changes	<u>GENITOURINARY</u> Increased Frequency of Urination Hesitation before Urination Abnormal Urine Color Changes	<u>CARDIAC</u> Shortness of Breath / Chest Pain Rapid Heart Rate / Swollen Ankles
<u>PULMONARY</u> Trouble Breathing Coughing	<u>GASTROINTESTINAL</u> Nausea / Vomiting / Gas Diarrhea / Constipation / Bloating	

Prior Injuries/Illnesses, Hospitalizations/ER, Surgeries, Traumas, Any Other Health Conditions:

Family Health History:

Other:

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, _____ of _____ attributed to aspirin use _____ is _____ risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Bender Chiropractic Health and Vitality Center

Effective: 4-15-2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Bender Chiropractic Health and Vitality Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Dr. William L. Bender

Bender Chiropractic Health and Vitality Center also uses protected health information for the following reasons: (you may opt out of this authorization). Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial to give us authorization)

If you have any questions regarding this notice or our health information privacy policies, please contact:

Dr. William L. Bender

You can reach the Privacy Official at: Bender Chiropractic Health and Vitality Center, 33580 Harper Avenue, Clinton Township, MI, 1-586-738-6833

Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____ (you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

=====

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
Other:

Staff Signature: _____ date: _____