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: ❑ CASH ❑ CHECK ❑ CREDIT CARD	

ABOUT YOUR SPOUSE

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

HEALTH HABITS

DO YOU SMOKE?	❑ YES	❑ NO	If yes, how much per day_____
DO YOU DRINK ALCOHOL?	❑ YES	❑ NO	If yes, how much per week_____
DO YOU DRINK COFFEE, TEA, OR SODA			If yes, how much per day_____
DO YOU EXERCISE REGULARLY?	❑ YES	❑ NO	
DO YOU WEAR: ❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS			

CHIROPRACTIC EXPERIENCE

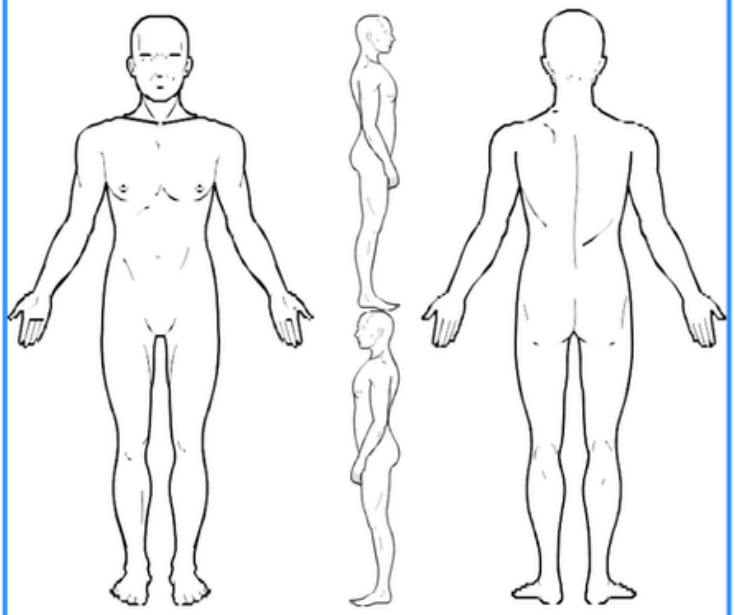
WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): ❑ FACEBOOK ❑ STREET SIGN ❑ FAMILY ❑ FRIEND ❑ COMMUNITY EVENT ❑ GOOGLE
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ❑ YES ❑ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

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

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

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

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.*

❑ SEVERE OR FREQUENT HEADACHES	❑ THYROID PROBLEMS	❑ PAIN IN ARMS/ LEGS/HANDS	❑ NUMBNESS	**FOR WOMEN ONLY:**
❑ HEART SURGERY/ PACEMAKER	❑ SINUS PROBLEMS	❑ LOW BLOOD PRESSURE	❑ ALLERGIES	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ LOWER BACK PROBLEMS	❑ HEPATITIS	❑ RHEUMATIC FEVER	❑ DIABETES	IF YES, WHEN IS YOUR DUE DATE?
❑ DIGESTIVE PROBLEMS	❑ DIFFICULTY BREATHING	❑ ULCERS/COLITIS	❑ SURGERIES:	ARE YOU NURSING? ❑ YES ❑ NO
❑ PAIN BETWEEN SHOULDERS	❑ KIDNEY PROBLEMS	❑ TUBERCULOSIS	❑ ASTHMA	ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
❑ CONGENITAL HEART DEFECT	❑ HIGH BLOOD PRESSURE	❑ ARTHRITIS	❑ LOSS OF SLEEP	<u>DO YOU:</u> EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO HAVE IRREGULAR CYCLES? ❑ YES ❑ NO
❑ FREQUENT NECK PAIN	❑ CHEMOTHERAPY	❑ SHINGLES	❑ DIZZINESS	HAVE BREAST IMPLANTS? ❑ YES ❑ NO

PATIENT CASE HISTORY

CHIEF CONCERNS:

When did this happen?	How did this happen? (circle answer) Job: Filed a workers comp. claim Yes / No Auto Accident: Filed insurance claim Yes / No Other:_____	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) □ No □ 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)

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

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

Family Health History:

Other:

Bender Chiropractic Health & Vitality Center
33580 Harper Ave.
Clinton Township, MI 48035

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: _____

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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: _____

New Patient Cancellation Policy Script
Scheduling and 1st email

After you have scheduled the new patient's appointment (with address), say:

"OK, great! Now to reserve your spot, we need to get a credit card on file. We won't charge the card now; we just ask for at least 24 hours' notice if you need to cancel or reschedule. If we don't receive that notice, a $25 cancellation fee will be charged to the card. But when you reschedule, that amount will be applied to your new patient appointment.

After we wrap up, I'll email you all the details, including our cancellation policy."

If the patient asks why there's a cancellation fee or voices concern or pushback:

- "We reserve about an hour for you with our doctor and clinical assistant, so short-notice cancellations create a huge gap in our schedule where we can't help other patients."

- "Many offices require payment upfront nowadays, but we only charge the card if we don't get a 24 hour notice."

If the patient asks about emergencies

"If there's an emergency, just call us as soon as you can. We're usually able to waive the fee in true emergency situations."

If the patient is uncomfortable providing CC info over the phone:

"I understand your concern but just so you know, our system is completely protected to safeguard your information. So would you be ok with sharing that number?"

OR

"We can't run your card without your permission."

If they still don't feel comfortable giving the CC info:

"Ok, I'll go ahead and make an exception because I want you to get the help you need."

Email cancellation notice

We ask for at least 24 hours' notice if you need to cancel or reschedule your new patient appointment. If we don't receive that notice, a $25 cancellation fee will be charged to the card on file.