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

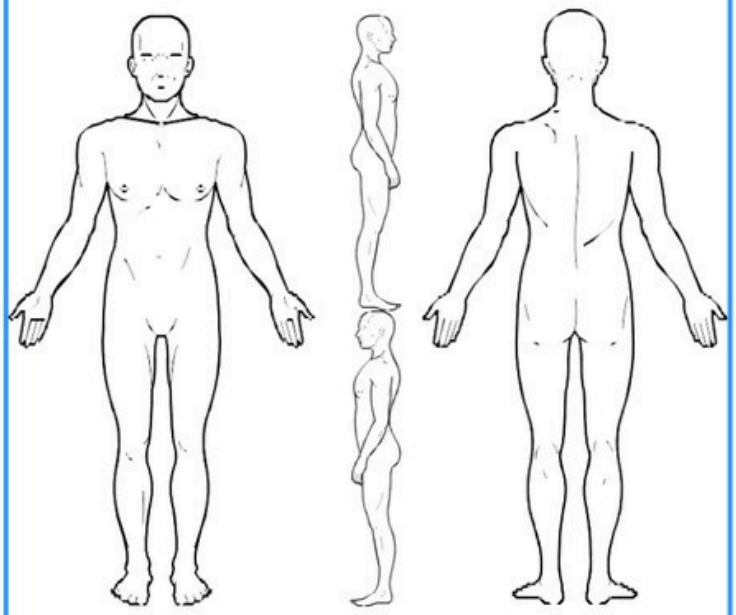
WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): ❑ FACEBOOK ❑ STREET SIGN ❑ FAMILY ❑ FRIEND ❑ COMMUNITY EVENT ❑ GOOGLE
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ❑ YES ❑ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE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

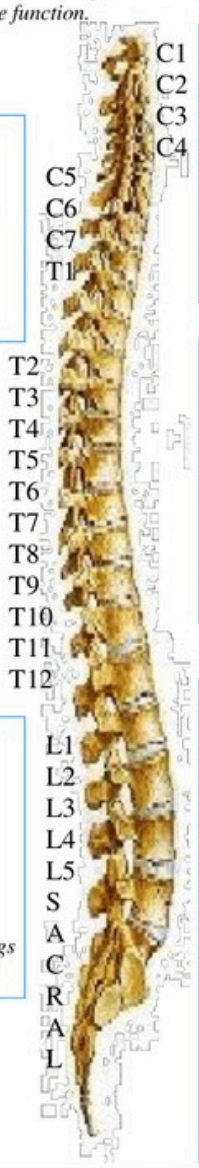
MEDICATIONS YOU TAKE

❑ 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

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, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and 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:

Bender Chiropractic Health & Vitality Center

New Patient Cancellation Policy

Welcome to Bender Chiropractic Health & Vitality Center! We look forward to serving you on your healthcare journey!

We are reserving about an hour for you to meet with your doctor and our clinical assistant, so short-notice cancellations create a large gap in our schedule where we could be helping other patients.

Because of that, we ask for at least a 24-hour notice if you need to cancel orreschedule your appointment. You can call anytime, just be sure to leave avoicemail with a detailed message if you are calling after hours.

Ifwe don’t receive a 24-hour notice, a $25 cancellation fee will be charged toyour credit card on file.

Thank you!

_____ _____

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: _____