PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name_____

Address_____ Apt#_____

City _____State_____ Zip _____

Home Phone _____ Cell Phone_____

Social Security#_____ Age _____

Birth Date:_____ Height _____Weight_____

Marital Status ☐M ☐S ☐W ☐D # of children _____

Employer/Type of Work _____

Work address _____Work phone_____

Email _____

What is your physical activity at work? ☐ Heavy ☐ Light

☐ Sitting (more than 50%) ☐ Moderate

Which phone number would you prefer we use?

☐ Home ☐ Cell ☐ Work

ABOUT THE PARTNER

Name _____

Employer _____

Work phone _____

Type of work _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is this visit related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall ☐ Wellness

☐ Home Injury ☐ Chronic Discomfort ☐ Other

Please explain _____

If job related, have you made a report of your accident to your employer?

☐ Yes ☐ No

When did this condition begin? _____

Has this condition:

☐ gotten worse ☐ stayed constant ☐ comes and goes

Does this condition interfere with:

☐ Work ☐ Sleep ☐ Daily routine ☐ Other activities

Please explain _____

Has this condition occurred before? ☐ Yes ☐ No

Please explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name (s) _____

Type of treatment _____

Results _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office?_____

Have you seen us advertised? ☐ Yes ☐ No

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits? _____

Doctor's name:_____

Approximate date of last visit:_____

Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No

Has any child in your family seen a Chiropractor? ☐ Yes ☐ No

HEALTH HABITS

	No	Yes
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Is your diet generally healthy?	☐	☐

What type of regular exercise do you perform?

☐ None ☐ Light ☐ Moderate ☐ Strenuous

Please Describe_____

_____

Perline Chiropractic 920 3rd Avenue, 6th Floor, New York, NY 10022 ph: 212-371-0700

AWARENESS OF THE CHIROPRACTIC PRINCIPLES

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

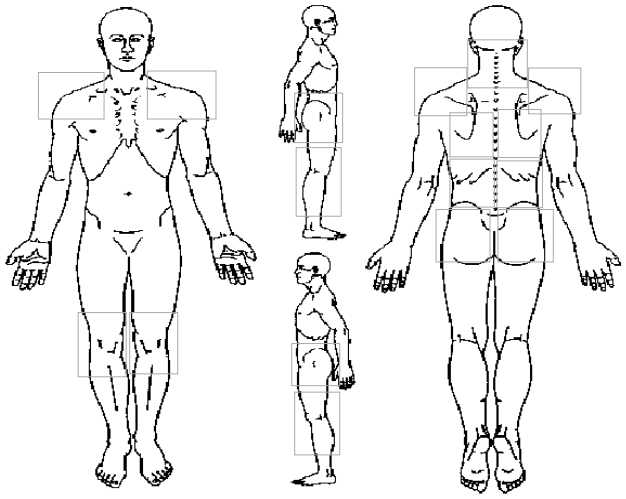
Chiropractic is safe and effective for children and pregnant women? ☐ Yes ☐ No

GOALS FOR MY 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 bodies. 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 type of care appropriate for my condition.**

Please 'Mark' The Area(s) Of Concern



☐ Throbbing ☐ Aching ☐ Stiffness
☐ Sharp ☐ Shooting ☐ Cramps
☐ Dull ☐ Burning ☐ Tingling
☐ Numbness ☐ Swelling ☐ Extreme Tightness

MEDICATIONS I NOW TAKE...

☐ Cholesterol Medication
☐ Blood Pressure Medication
☐ Stimulants
☐ Blood Thinners
☐ Sleep Aids
☐ Pain killers (including aspirin)
☐ Muscle Relaxers
☐ Antidepressants
☐ Insulin
☐ Hormonal Replacement

Vitamins & Supplements I now take:_____

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have had now or 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.

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
Do you have breast implants? ☐ Yes ☐ No
Are you still getting your period? ☐ Yes ☐ No
Did you or are you experiencing back and/or leg pain during your pregnancy? ☐ Yes ☐ No

☐ Severe or frequent headaches
☐ Sinus problems
☐ Dizziness
☐ Loss of sleep
☐ Depression/Anxiety
☐ High/Low blood pressure
☐ Unexplained weight gain/loss
☐ Numbness in Arms/legs/hands
☐ Asthma
☐ Lower back problems
☐ Digestive problems
☐ Heart surgery/pacemaker
☐ Heart attack/stroke
☐ Heart murmur
☐ Congenital heart defect
☐ Cancer_____
☐ Chemotherapy
☐ Difficulty breathing
☐ Alcohol/drug abuse
☐ Rheumatic fever
☐ HIV/AIDS
☐ Ulcers/Colitis
☐ Arthritis
☐ Shingles
☐ Kidney problems
☐ Diabetes
☐ Thyroid problems
☐ Hepatitis
☐ Tuberculosis

Other: _____
_____
_____

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.
All accounts not paid within 90 days will *automatically* be put through on your credit card.

☐ MasterCard ☐ Visa ☐ American Express Card # _____ Exp. Date _____ CVV _____

_____ _____
Signature Date

_____ _____
Guardian or Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account?

☐ **Patient** ☐ **Spouse** ☐ **Parent** ☐ **Worker's Comp** ☐ **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 important that each 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 reduce interference to the expression of the body's innate intelligence. Our only method is specific adjusting to correct vertebral subluxations.

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.

Patient's Signature _____Date_____

Witness_____

Patient Case History Cont.

Are there any associated symptoms (headaches, pain with breathing, muscle weakness) _____

Are there any aggravating factors that you are aware of _____

What has been done to help this condition _____

Please describe any prior illnesses, surgeries, injuries _____

Family health history (diabetes, cancer, heart disease) _____

How would you grade your general stress level ☐Low ☐Moderate ☐Severe
Please explain _____

Please include anything you think might help us to better understand your condition _____

...thank you

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 it's staff.

I understand that, under the 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 physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand hat I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name (Print):_____

Relationship to Patient:_____

Signature:_____ Date:_____