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About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage our health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the systems. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. Finally, Chiropractic offers a genuine approach to **Wellness Care**.
All of these options will be explained at your report of findings. Then you will be able to begin a course of care that fits your health goals

Loss of Wellness (Birth to Age 5)

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health starts.

Yes No (Birth – Age 5) (If Yes Answer)

1. Did your mother:

□ □ Smoke or drink alcohol? ____________________
□ □ Have a proper diet? ____________________
□ □ Exercise through her pregnancy? ____________________
□ □ Experience any falls or injuries during pregnancy? ____________________
□ □ Experience any physical and/or mental abuse? ____________________

2. Birth Process:

Yes No

□ □ Was the delivery long? ____________________
□ □ Was the delivery difficult? ____________________
□ □ Were Forceps used? ____________________
□ □ Caesarean delivery? ____________________
□ □ Breach/cephalic delivery? ____________________
□ □ Home birth? ____________________
□ □ Hospital birth? ____________________
□ □ Mother given drugs during delivery? ____________________
□ □ Was labor induced?

3. Growth and Development:

Yes No

□ □ Were you taught how to care for your spine? ____________________
□ □ Did you roll out of bed? ____________________
□ □ Were you breast fed? ____________________
□ □ Childhood sicknesses? ____________________

☐	☐	Accidents?	______
☐	☐	Surgery?	______
☐	☐	Drugs?	______
☐	☐	Did you fall while learning to walk?	______
☐	☐	Were you picked on by siblings?	______
☐	☐	Child abuse?	______
☐	☐	Spanking (how?)	______
☐	☐	Pulled ear/chin?	______
☐	☐	Other?	______
☐	☐	Chair pulled out when sat down?	______
☐	☐	Did you fall down stairs?	______
☐	☐	Were you yanked by your arm?	______
☐	☐	Did you have other traumas? What? When?	______

Loss of Whole Body Health (Age 5-Present)

As layers of damage increased, you probably began to experience symptoms and random bouts of sickness.

Yes	**No**	**(Age 5 – Present)**	**(If Yes Answer)**
☐	☐	Were you taught proper body movement and care?	______
☐	☐	Did/do you smoke? (Date quit :____________) No. years	______
☐	☐	Did/do you drink any alcohol?	______
☐	☐	Do you eat a healthy diet?	______
☐	☐	Have you ever had any accidents?	______
☐	☐	Have you had surgery and/or organs removed/replaced?	______
☐	☐	Drugs? (Prescriptive or non-Prescriptive)	______
☐	☐	Teeth problems?	______
☐	☐	Eye problems?	______
☐	☐	Hearing problems?	______
☐	☐	Exercise regularly?	______
☐	☐	Sleeping habits? (nightmares?)	______
☐	☐	Did/do you have occupational stress?	______
☐	☐	Physical stress?	______
☐	☐	Mental stress?	______
☐	☐	Hobbies/sports injuries?	______
☐	☐	Other traumas or problems?	______

Symptoms and Ill Health (Present State of Ill Health-Past 12 Months)

Years of untreated damage showed up as acute or chronic symptoms

***Other* Symptoms**

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold
☐ Neck Stiff	☐ Constipation	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐Tingling in legs/feet	☐ Face Flushed
☐ Nausea	☐ Back Pain	☐ Numbness in arms/hands	☐ Buzzing in Ears
☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting
☐ Fever	☐ Fatigue	☐ Irritability	☐ Loss of Smell
☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength-arms	☐ Burning muscle pain	☐ Loss of strength-legs	☐ Difficulty swallowing
☐ Sharp/shooting pain	☐ Depression	☐ Stomach Upset	☐ Face Flushed

Present Complaint:

Major complaint: ____________________

Pain or Problem started when: ____________________

Describe your pain: □ Burning □ Sharp □ Dull □ Ache □ Constant □ Intermittent

Is condition getting progressively worse? □ Yes □ No

What caused it? ____________________

What activities aggravate your condition/pain? ____________________

Is condition worse during certain times of the day? □ Yes □ No If so, when?____________________

Is this condition interfering with (check those that apply):
□ Work □ Sleep □ Routine □ Other____________________

Symptoms and Ill Health (cont'd)

Is this condition interfering with (circle those that apply):
□ Work □ Sleep □ Routine □ Other____________________

What relieves it? ____________________

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? □ Yes □ No

Other healthcare providers seen for this condition? ____________________

Any home remedies used? ____________________

Have you been under any drug and medical care? □ Yes □ No

If yes, please explain: ____________________

Please list medications you are currently taking: ____________________

____

Patient History

Have you had surgery □ Yes □ No

If yes, please list the date and type:

____

____

____

____

____

____

What side effects (if any) did you experience from the drugs and/or surgery? ____________________

____

____

____

Family History

Father's Side	**Mother's Side**
□ Heart Disease	□ Heart Disease
□ Arthritis	□ Arthritis
□ Cancer	□ Cancer
□ Diabetes	□ Diabetes
□ Other:____________	□ Other:____________

Patient Information

Date: _____________ Name: ____ SSN: ___________________________
(Required for Medicare/Medicaid)

DOB: ________________ E-mail: ____

Address: ___________________________________ City: ________________________ State: _______ Zip: __________

Home Phone: _____________________ Work Phone: ______________________ Cell Phone: ______________________

Gender: □ Male □ Female Age: ________ If you were referred, by whom? ___________________________________

Occupation: _______________________________________ Employer: ____

Marital Status: S M D W Spouse's Name: ____________________________ & Occupation: ______________________

Number of Children and Ages: ____

Have you ever received Chiropractic Care? □ Yes □ No If so, with whom?_______________________________________

Approximate date of last adjustment ____

Have you ever been in an accident? □ Yes □ No Type? □ Work □ Auto □ Other: __________ When? ____________

Did you feel a popping or tearing noise in your back or neck? □ Yes □ No

Did you require post-accident hospitalization? □ Yes □ No If so, Where? __________________ When? ______________

Were X-rays taken? □ Yes □ No Did you lose days at work as a result? □ Yes □ No How Many? _______________

Is/Was insurance involved? □ Yes □ No If so, which company? ____

Attorney's name: □ N/A _____________________________ Claim #: ____________________ ______________________
Comments (office use only)

CONSENT FOR RADIOLOGY

I, ____ give the doctors of Reister Family Chiropractic, my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of the office.

I also give my consent for films of my child/children for the same reasons, if applicable.

FOR LADIES ONLY:

To my best knowledge, I am not pregnant and know of no contraindications for x-ray at this time.

_______________________________________ _________________________

Patient signature **Date**

Consent for Purpose of Treatment, Payment and Healthcare Operations (HIPPA)

Regarding the Use & Disclosure of Health Information

I acknowledge that **Reister Family Chiropractic** “Notice of Privacy Practices” has been provided to me.

I understand I have a right to review Reister Family Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Reister Family Chiropractic. The Notice of Reister Family Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Reister Family Chiropractic duties with respect to my protected health information.

Reister Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

PATIENT ACKNOWLEGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Signature: ____ Date: ___________________

Print Name: ____

Name: _____________________________________ Relation/Authority: _________________________
(If personal representative used)

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept that patient for care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important to understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of a subluxation, restoring proper biomechanics. Our chiropractic method of correction is by specific adjustment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column. Which cause alteration of nerve functions and interference to the transmission of impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual 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 eliminate interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct subluxation. No adjustment/treatment guarantees the desired result.

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I, ____________________________________ have read and fully understand the above statements. All 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.

Signature____ Date ________________

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic to the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward and total charges for professional services rendered by this clinic.

____ ____________________
Patient Signature Date

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to my insurance company, adjustor and attorney involved in this case and hereby release this clinic of any consequence there of.

____ ____________________
Patient Signature Date

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

____ ____________________
Patient Signature Date

* **Medicare/Medicaid patients:**
We need your **Social Security Number** for Billing/Insurance purposes.

EMERGENCY CONTACT SHEET

Patient's Name ____

Primary Contact:

Name ____ Relationship ________________

Address ____

____

Phone ____

Secondary Contact:

Name ____ Relationship ________________

Address ____

____

Phone ____