

ADULT MEMBER HEALTH RECORD

ABOUT YOU

| | | |
|--------------------------------------------------------------|--------------------------|---------|
| NAME: (LAST, FIRST, MI) | | DATE: |
| ADDRESS: | | |
| CITY: | STATE/ZIP CODE: | |
| HOME PHONE: | CELL PHONE: | |
| EMAIL ADDRESS: | | |
| | | |
| DATE OF BIRTH: | AGE: | GENDER: |
| SOCIAL SECURITY NUMBER: | NAME & AGES OF CHILDREN: | |
| MARITAL STATUS: | | |
| | | |
| WHO REFERRED YOU TO OUR OFFICE OR HOW DID YOU HEAR ABOUT US? | | |
| EMPLOYER NAME : | | |
| EMPLOYER ADDRESS: | EMPLOYER STATE/ZIP CODE: | |
| WORK PHONE: | POSITION TITLE: | |
| | | |
| INSURANCE COMPANY: | | |
| INSURED'S NAME : | | |
| INSURED'S SOCIAL SECURITY NUMBER: | | |
| INSURED'S DATE OF BIRTH: | | |

ABOUT YOUR SPOUSE

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

| |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO PACKS PER DAY? _____ |
| DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO DRINKS PER DAY? _____ |
| DO YOU DRINK COFFEE, TEA OR SODA? <input type="checkbox"/> YES <input type="checkbox"/> NO DRINKS PER DAY? _____ |
| DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO HOURS PER WEEK? _____ |
| CIRCLE ONE: LIGHT MODERATE STRENUOUS |
| DO YOU WEAR: <input type="checkbox"/> HEAL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS |

WERE YOU AWARE THAT...

| |
|----------------------------------------------------------------------------------------------------------------------------------|
| DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? <input type="checkbox"/> YES <input type="checkbox"/> 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.

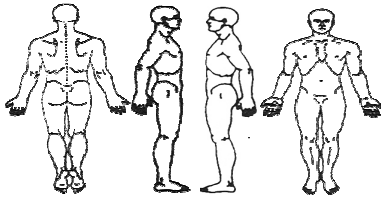
- Relief care:** Symptomatic relief of pain or discomfort.
- Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible
- I want the Doctor to select the type of care appropriate for my condition.

MEDICATIONS YOU TAKE

| |
|---------------------------------------------------------------|
| Please List What Conditions You Take Medications For : |
| |
| Please List All Vitamins and Supplements You Take: |
| |

REASON FOR THIS VISIT

PLEASE LIST YOUR PRIMARY COMPLAINTS:



****MARK THE BODY WITH AN "X" WHERE YOU FEEL THE DESCRIBED PAIN SENSATIONS:
**RATE THE PAIN:
NO PAIN: 0
MINIMAL PAIN: 1/2
TOLERABLE PAIN: 4/5
HIGH PAIN: 6/7
EXTREME PAIN: 7/8
UNBEARABLE: 9/10**

WHERE IS THE PAIN LOCATED? LEFT RIGHT BOTH
 CENTER

WHEN DID THIS CONDITION BEGIN?

WAS THE ONSET : GRADUAL SUDDEN

WHAT CAUSED THE INJURY AND WAS THERE AN UNUSUAL ACCIDENT OR INJURY INVOLVED?

IS YOUR CURRENT COMPLAINT: INFREQUENT <25%
 OCCASIONAL 25% to 50% FREQUENT 50% to 75%
 CONSTANT > 75%

THE SEVERITY OF YOUR PAIN IS: MILD
 MILD TO MODERATE MODERATE
 MODERATE TO SEVERE SEVERE

IS YOUR PAIN: SHARP DULL ACHING STIFF SORE
BURNING TINGLING/NUMB EXCRUCITATING
OTHER

HAS THIS CONDITION:
 GOTTEN WORSE STAYED CONSTANT COME AND GONE

WHAT MAKES THE PAIN FEEL BETTER? MEDICATION
 LYING DOWN STANDING SITTING STRETCHING
 RANGE OF MOTION ICE HEAT NOTHING

OTHER

WHAT MAKES THE PAIN FEEL WORSE? MOVEMENTS
 BENDING TWISTING WEIGHT BEARING
 MOVEMENTS NECK FLEXION SNEEZING SITTING
 STANDING WALKING CHEWING YAWNING
 OPENING MOUTH CLOSING MOUTH
 RANGE OF MOTION PUSHING/PULLING LIFTING
 WATCHING TV READING WORKING DRIVING
 HOUSEWORK BRIGHT LIGHTS
 LOUD NOISES
OTHER

DOES THIS CONDITION INTERFERE WITH:
 WORK SLEEP DAILY ROUTINE OTHER ACTIVITIES

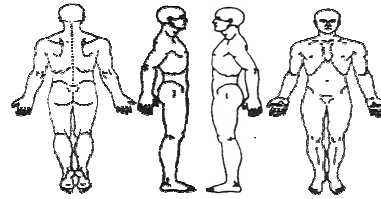
HAS THIS CONDITION OCCURRED BEFORE? YES NO
IF YES, PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?
 YES NO

COMMENTS:

REASON FOR THIS VISIT

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 LOUD NOISES
OTHER

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HAS THIS CONDITION OCCURRED BEFORE? YES NO
IF YES, PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?
 YES NO

COMMENTS:

MEDICAL CARE INFORMATION

| | |
|------------------------------------------------------------------------------------------------|----------------------------------------------|
| DO YOU HAVE A FAMILY DOCTOR? YES NO | |
| NAME OF DOCTOR: | |
| ADDRESS: | |
| CITY: | STATE: ZIP: |
| DATE OF LAST VISIT: | DATE OF LAST EXAM: |
| DO YOU HAVE A FAMILY CHIROPRACTOR? YES NO | |
| NAME OF CHIROPRACTOR: | |
| ADDRESS: | |
| CITY: | STATE: ZIP: |
| DATE OF LAST VISIT: | DATE OF LAST EXAM: |
| HAVE YOU HAD SURGERIES IN THE LAST 5 YEARS: YES NO IF YES, LAST SURGERY DATE: | |
| REASON FOR SURGERY: | |

FAMILY HISTORY OF ILLNESS

INSTRUCTIONS: Please circle the illness below if it affected a person in your family. SB= sibling P= parent C=Child

| | | | |
|------------------------------|---------------------------------------|--------------------------------------------------|----------------------------------|
| Headaches SB P C | CIRRHOSIS/ HEPATITIS SB P C | KIDNEY TROUBLE SB P C | SINUS TROUBLE SB P C |
| ALLERGIES SB P C | DIABETES SB P C | BACK PROBLEMS SB P C | EPILEPSY SB P C |
| ANEMIA SB P C | DISLOCATED JOINTS SB P C | LOW BLOOD PRESSURE SB P C | THYROID TROUBLE SB P C |
| ARTHRITIS SB P C | MULTIPLE SCLEROSIS SB P C | MENTAL/ EMOTIONAL DIFFICULTY SB P C | TUBERCULOSIS SB P C |
| ASTHMA SB P C | HEART PROBLEM SB P C | PROSTATE TROUBLE SB P C | ULCER SB P C |
| CANCER SB P C | REPRODUCTIVE SB P C | RHEUMATIC FEVER SB P C | EAR PROBLEMS SB P C |
| BONE FRACTURE SB P C | HIGH BLOOD PRESSURE SB P C | ADD/ADHD SB P C | SCOLIOSIS SB P C |
| DIVERTICULITIS SB P C | OTHER: | | |

PRESENT CONCERNS

INSTRUCTIONS: Please **CIRCLE** the health concerns or conditions you may be experiencing NOW. 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

High Blood Pressure

Heart Conditions

C1

C2

C3

C4

C5

C6

C7

T1

T2

T3

T4

T5

T6

T7

T8

T9

T10

T11

T12

L1

L2

L3

L4

L5

S

A

C

R

A

L

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 Problems

OTHER:



HEALTH HISTORY

INSTRUCTIONS: Please check each of the diseases or conditions that **you 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"/> HIGH BLOOD PRESSURE | ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO I declare at this time, to the best of my knowledge, that I am not pregnant and Dr. Taylor and associates have my permission to perform X-Ray evaluation. _____ |
| <input type="checkbox"/> LOWER BACK PROBLEMS | <input type="checkbox"/> HEPTATIS | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> DIABETES | IF YES, WHEN IS YOUR DUE DATE? |
| <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> DIFFUCLTY BREATHING | <input type="checkbox"/> ULCERS/COLITIS | <input type="checkbox"/> PACEMAKER/ STENTS | ARE YOU NURSING? <input 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"/> DIZZINESS | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> LOSS OF SLEEP | DO YOU: EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU 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"/> OTHER | |

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 only when the 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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

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.

SIGNATURE:

DATE:

WITNESS SIGNATURE:

DATE:

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.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| SIGNATURE: | DATE: |
| GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE: | DATE: |
| WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT? | |
| <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> WORKERS COMP <input type="checkbox"/> AUTO INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> HEALTH INSURANCE | |

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 its staff.

I understand that, 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 physician's certifications.

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

| | |
|------------------------------|--------------------------|
| PATIENT NAME (PLEASE PRINT): | RELATIONSHIP TO PATIENT: |
| SIGNATURE: | DATE: |

Taylor Family Chiropractic
909 Main St.
Bastrop, TX 78602