Premier Family Healthcare, LLC
Chiropractic Lifestyle Center

Adult Member Health Record

ABOUT YOU

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

DATE OF BIRTH: | AGE:

GENDER: ☐ MALE ☐ FEMALE

MARITAL STATUS: | NUMBER OF CHILDREN:

EMPLOYER NAME:

WORK PHONE: | POSITION TITLE

HEALTH HABITS

DO/DID YOU SMOKE? ☐ YES ☐ NO

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

DO YOU DRINK COFFEE, TEA OR SODA? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

DO YOU WEAR:

☐ HEEL LIFTS ☐ SOLE LIFTS ☐ INNER SOLES ☐ ARCH SUPPORTS

MEDICATIONS YOU TAKE

☐ CHOLESTEROL MEDICATIONS ☐ INSULIN

☐ STIMULANTS ☐ PAIN KILLERS

☐ TRANQUILIZERS ☐ BLOOD PRESSURE MEDICINE

☐ MUSCLE RELAXERS ☐ OTHER _____

SUPPLEMENTS YOU TAKE

☐ OMEGA SUPPLEMENT ☐ PROBIOTIC

☐ MULTIVITAMINS ☐ VITAMIN D

☐ CALCIUM/MAGNESIUM ☐ OTHER _____

☐ VITAMIN C ☐ OTHER _____

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):

☐ NEWSPAPER ☐ SIGN ☐ YELLOW PAGES

☐ COMMUNITY EVENT ☐ MAILING ☐ OTHER _____

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ☐ YES ☐ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTORS NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: ☐ WELLNESS ☐ CONDITION

IF CONDITION, DESCRIBE:

IS THE PURPOSE OF THIS VISIT RELATED TO: ☐ SPORTS ☐ AUTO ☐ FALL ☐ HOME INJURY ☐ OTHER

PLEASE EXPLAIN:

WHEN DID THIS CONCERN BEGIN?

HAS THIS CONCERN: ☐ GOTTEN WORSE ☐ STAYED CONSTANT ☐ COME AND GONE

DOES THIS CONCERN INTERFERE WITH: ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER ACTIVITIES

PLEASE EXPLAIN:

HAS THIS CONCERN OCCURRED BEFORE? ☐ YES ☐ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? ☐ YES ☐ NO

DOCTORS NAME:

TYPE OF TREATMENT:

RESULTS: ☐ GOOD ☐ BAD ☐ INDIFFERENT

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ARE 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 choose chiropractic as vital part of their health and wellness by being proactive and making it a part of their lifestyle. 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 and discomfort

☐ **Corrective care:** Corrective and relieving the cause of the problem as well as the symptoms.

☐ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

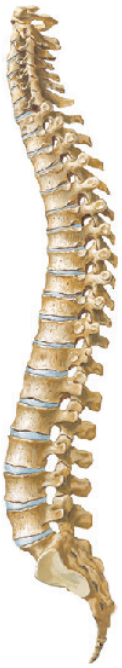
☐ ***I want the Doctor to select the type of care for my condition.***

YOUR CONCERNS

PLEASE CIRCLE ANY THAT CURRENTLY APPLY TO YOU.

SORE THROAT
STIFF NECK
RADIATING ARM PAIN
HAND FINGER NUMBNESS
ASTHMA
HIGH BLOOD PRESSURE
HEART CONDITIONS

CONSTIPATION
COLITIS
DIARRHEA
GAS PAIN
IRRITABLE BOWEL
BLADDER PROBLEMS
MENSTRUAL PROBLEMS
LOW BACK PAIN
PAIN AND NUMBNESS IN LEGS
REPRODUCTIVE PROBLEMS



HEADACHES
MIGRAINES
DIZZINESS
SINUS PROBLEMS
ALLERGIES
FATIGUE
HEAD COLDS
VISION PROBLEMS

MIDDLE BACK PAIN
CONGESTION
DIFFICULTY BREATHING
BRONCHITIS
PNEUMONIA
GALLBLADDER CONDITIONS
STOMACH PROBLEMS
ULCERS
GASTRITIS
KIDNEY PROBLEMS

OTHER

ARE YOU HEALTHIER TODAY THAN YOU WERE 5 YEARS AGO? ☐ YES ☐ NO

IF SO, WHAT DID YOU DO TO IMPROVE YOUR HEALTH?

IF NOT, WHY DO YOU THINK YOUR HEALTH HAS DECLINED?

WILL YOU BE HEALTHIER 5 YEARS FROM NOW THAN YOU ARE TODAY?

☐ YES ☐ NO ☐ UNSURE

IF SO, WHAT ARE YOU PLANNING TO DO TO IMPROVE YOUR HEALTH AND IF NOT, WHAT COULD YOU DO TO IMPROVE YOUR HEALTH RATHER THAN HAVE IT DECLINE?

IF THERE IS A NEED FOR DIETARY CHANGES TO HELP YOU ACHIEVE A GREATER LEVEL OF WELLNESS, WOULD YOU LIKE TO BE INFORMED? ☐ YES ☐ NO

IF THERE IS A NEED FOR SPECIFIC EXERCISES, WOULD YOU LIKE TO BE INFORMED? ☐ YES ☐ NO

IF THERE IS A NEED FOR SUPPORT IN THE PSYCHOLOGICAL MIND/STRESS DIMENSION FOR HEALTH, WOULD YOU LIKE TO BE INFORMED? ☐ YES ☐ NO

WOULD YOU LIKE TO BE INFORMED OF WHAT NUTRITIONAL SUPPLEMENTS OR FOODS MAY HELP ADDRESS YOUR CURRENT HEALTH CONCERNS OR SYMPTOMS? ☐ YES ☐ NO

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
☐ HEART SURGERY/PACEMAKER	☐ SINUS PROBLEMS	☐ LOW BLOOD PRESSURE
☐ LOWER BACK PROBLEMS	☐ HEPATITIS	☐ RHEUMATIC FEVER
☐ DIGESTIVE PROBLEMS	☐ DIFFICULTY BREATHING	☐ ULCERS/COLITIS
☐ PAIN BETWEEN SHOULDERS	☐ KIDNEY PROBLEMS	☐ TUBERCULOSIS
☐ CONGENITAL HEART DEFECT	☐ HIGH BLOOD PRESSURE	☐ ARTHRITIS
☐ FREQUENT NECK PAIN	☐ CHEMOTHERAPY	☐ SHINGLES
☐ NUMBNESS	☐ ALLERGIES	☐ DIABETES
☐ ASTHMA	☐ LOSS OF SLEEP	☐ DIZZINESS
Covid Shot ☐ YES ☐ NO Qty____	Last Booster _____	Covid Illness? When _____
☐ SURGERIES: (PLEASE LIST ALL)		

WOMEN ONLY

ARE YOU PREGNANT? ☐ YES ☐ NO

IF YES, WHEN IS YOUR DUE DATE?

ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU TAKING BIRTH CONTROL? ☐ YES ☐ NO

DO YOU:
EXPERIENCE PAINFUL PERIODS? ☐ YES ☐ NO

HAVE IRREGULAR CYCLES? ☐ YES ☐ NO

HAVE BREAST IMPLANTS? ☐ YES ☐ NO

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"It is easier to build strong children than repair broken adults."

AUTHORIZATION TO RELEASE INFORMATION

In the event that you are not available to receive personal information, such as lab results, billing information, and/or medical information your consent is required in order for another person to obtain this information.

I authorize Premier Family Healthcare and/or their staff to leave medical information to the following people: Please list names of authorized people and what type of information we may release to them:

Name: _____ Relation:_____

Medical _____ Billing_____ Appointments_____ All_____ Other_____

Name: _____ Relation: _____

Medical _____ Billing_____ Appointments_____ All_____ Other_____

I authorize Premier Family Healthcare and/or their staff to release any information required in the course of my examinations or treatments.

Patient/Guardian Signature: _____ Date: _____

Print Patient Name: _____

I **do not** authorize any information to be released to anyone other than myself.

Patient/Guardian Signature: _____ Date: _____

Print Patient Name: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you were offered a copy of the Notice of Privacy Practices for Premier Family Healthcare, LLC, (H.I.P.P.A.) located at the front desk.

The Notice explains how your medical information can be used and disclosed and how you can access that information. We encourage you to read it. If you have any questions, call the contact person on the front of the Notice.

I acknowledge that I was offered the Notice of Privacy Practices of Premier Family Healthcare, LLC, and the other health care providers that are part of its system, including those listed on the front of the Notice.

Print Name: _____ Date: _____

Signature: _____

Relationship to Patient (if under 18): _____

AUTHORIZATION FOR CARE

I hear by authorize the doctors in this chiropractic office and whoever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor 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.

Print Name: _____Date: _____

Signature: _____

Relationship to Patient (if under 18): _____