Amplus FAMILY CHIROPRACTIC

Adult Health History

Personal Information

Name _____ Age _____ Date of Birth _____ Gender _____

Home Address _____ City _____ State____ Zip _____

Cell Phone _____ Home Phone _____

Email Address_____

Occupation _____ Employer _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Spouse's Name _____

Spouse's Age _____ Spouse's Occupation _____

Emergency Contact: Name _____ Relationship _____

Emergency Contact Phone _____

Whom may we thank for referring you to our office? _____

Number of Children and Ages

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Previous Chiropractic Care?

Yes ___ No ___ Reason _____

Yes ___ No ___ Reason _____

Yes ___ No ___ Reason _____

Yes ___ No ___ Reason _____

Yes ___ No ___ Reason _____

Health Care Practitioner History

Have you ever received chiropractic care? ☐ Yes ☐ No Reason _____

Name of previous chiropractor _____ Date of last visit _____

How long were you under care? _____ Why was care stopped? _____

Were you pleased with care? ☐ Yes ☐ No Please Explain _____

_____

_____

Reason for Seeking Chiropractic Care

What is your present complaint or concern? If no current complaint, what is the reason for your visit today?

_____

When did this condition begin? _____

How did the condition start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Amplus FAMILY CHIROPRACTIC

Is the condition: ☐ Getting Worse ☐ Improving ☐ Constant ☐ Intermittent ☐ Unsure

What makes the condition better? _____

What makes the condition worse? _____

Is the condition worse during certain times of the day? ☐ No ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Is this condition interfering with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Exercise ☐ Daily Routine

Have you ever had a similar condition? ☐ Yes ☐ No Please Explain _____

Who have you seen for this condition? _____

Were you pleased with care? ☐ Yes ☐ No Please Explain _____

Please check if you currently have or have had any of the following conditions:

☐ Acne
☐ Asthma
☐ Allergies
☐ Anxiety or Nervousness
☐ Autoimmune Disease
☐ Blurred Vision
☐ Cancer
☐ Chest Pains
☐ Cold Feet or Hands
☐ Cold Sweats
☐ Constipation/Diarrhea
☐ Depression
☐ Diabetes
☐ Digestive Problems
☐ Dizziness
☐ Ears Ringing
☐ Fainting
☐ Fatigue or Low Energy
☐ Gout
☐ Headaches
☐ Heartburn
☐ Heart Problems
☐ Hernia
☐ High Blood Pressure
☐ Irregular Menstrual Cycle
☐ Irritability
☐ Kidney Stones
☐ Loss of Balance
☐ Loss of Memory
☐ Loss of Smell or Taste
☐ Numbness Fingers/Toes
☐ PMS
☐ Poor Posture
☐ Prostate Trouble
☐ Scoliosis
☐ Sensitive to Light
☐ Shortness of Breath
☐ Sleeping Problems
☐ Stomach Ulcer
☐ Stroke
☐ Tendonitis
☐ Thyroid Condition
☐ Urinary Frequency
☐ Weight Gain/Loss

Other health concerns? _____

Family History

	Heart Disease	Arthritis	Cancer	Diabetes	Stroke
Father's Side	☐.	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

How old is/was your oldest grandparent or relative? _____

☐ Still living ☐ Deceased

Physical Stress

Please list the major traumas, hospitalizations, or surgeries from your childhood to the present _____

_____

Amplus FAMILY CHIROPRACTIC

Have you ever been involved in a car accident? ☐ Yes ☐ No If yes, please explain _____

_____

Have you ever been involved in any high impact or contact-type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ Yes ☐ No If yes, please explain _____

_____

Do you exercise? ☐ Yes ☐ No How often? ☐ 1-2x/week ☐ 3-4x/week ☐ 5x or more/week

Please list the type of exercise(s) _____

How many hours do you sleep a night? ☐ Less than 5 hours ☐ 5-7 hours ☐ 7-9 hours ☐ More than 9 hours

Do you wake up: ☐ Refreshed ☐ Tired & Groggy

How many hours a day do you typically spend sitting at a desk or on a computer, tablet, or phone?

☐ 1 hour or less ☐ 2-4 hours ☐ 4-6 hours ☐ 8 or more hours

Emotional Stress

In your own words, please explain any areas of your life that you feel are causing you significant emotional stress

_____

_____

_____

Using the scale below, please grade each of the following areas in your life

0 - No stress **1** - A little stress **2** - Moderate stress **3** - A lot of stress **4** - Extreme stress

Regarding my life in general	0 1 2 3 4
Regarding my relationships	0 1 2 3 4
Regarding my finances	0 1 2 3 4
Regarding my work and career	0 1 2 3 4
Regarding my health and well-being	0 1 2 3 4
Regarding my time management skills	0 1 2 3 4

Chemical Stress

Do you presently consume any of the following?

☐ Alcohol	☐ Dairy	☐ Prescribed Drugs
☐ Artificial Sweetener	☐ Gluten	☐ Processed Food
☐ Caffeine	☐ Over-the-Counter Drugs	

Please list any present prescription or over-the-counter drugs you are taking _____

Amplus FAMILY CHIROPRACTIC

Your Top 3 Health Goals

Please list your top 3 health goals (i.e. lose weight, exercise more, healthier diet, stress less, etc…)

1. _____
2. _____
3. _____

Expectations of Care

As a result of my chiropractic care, I would like to (Please check all that apply)

☐ Feel better quickly
☐ Correct the cause of the problem as well as relief
☐ Prevent future problems
☐ Live a healthier lifestyle
☐ Have a healthier spine and nervous system
☐ Attain optimal health on all levels
☐ Other_____

Thank you for trusting us at Amplus Family Chiropractic to help you and your family achieve a life of abundance.

Amplus
FAMILY CHIROPRACTIC

TERMS OF ACCEPTANCE

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

Adjustment: 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 of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental 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 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 subluxations.

I, _____ have read and fully understand the above statements.
(print name)

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 _____

Financial Policy

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange and agree to a recommended care plan payment schedule in advance. These plans are designed to be the most affordable way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition, and Lifestyle Care options. Details of these plans will be discussed with you during your Report of Findings on your second visit. Please choose one of the following documentation options:

☐ Insurance: If you have insurance that covers chiropractic care, Amplus Family Chiropractic will provide you with all the information you need to seek reimbursement. This includes your diagnosis codes and details of charges on a specialized receipt called a Superbill. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your second visit and then once per month after that. It is your responsibility to supply the Superbill to your insurance company, and they will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

☐ No Insurance: If you do not have health insurance, choose not to use your health insurance, or are participating in Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

I have read and understand the above policy. I have indicated the option that applies to me.

Signature _____ Date: _____

Healthcare Authorization

The following authorizes Amplus Family Chiropractic to use and/or disclose protected health care information in accordance with the following specific authorizations:

- I give permission to Amplus Family Chiropractic to use my name, address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, newsletters, patient of the week/month postings, information about treatment alternatives or other health related information.
- If Amplus Family Chiropractic contacts me by phone, I give them the permissions to leave a phone message on my answering machine or voicemail.
- I give permission to Amplus Family Chiropractic to use my first name on a welcome board, referral board, birthday board, and social media (Facebook, Instagram, etc.).
- I give permission to Amplus Family Chiropractic to use my photograph on the patient picture bulletin board and other marketing materials such as their brochure, website, ads in print media, and social media (Facebook, Instagram, etc.).
- I give permission to Amplus Family Chiropractic to use any testimonial written by me for marketing purposes such as; sharing with other patients or potential patients, in their brochure, on their website, ads in print media, and social media (Facebook, Instagram, etc.).
- I give permission to Amplus Family Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Amplus Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges: * The right to review the notice prior to signing this consent * The right to object to the use of my health care information for directory purposes * The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Consent to Care

I do hereby authorize the doctor(s) of Amplus Family Chiropractic to administer chiropractic care that is necessary for my particular case. This may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my health care. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I understand that payment for care is out-of-pocket and paid before or directly after services are rendered. If I wish to obtain reimbursement from my health insurance company, Amplus Family Chiropractic will supply the proper documentation necessary to receive reimbursement for services. Amplus Family Chiropractic is not liable for any lack of reimbursement from my health insurance company.

I have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Your Name: (Printed) _____

Signature _____ Date: _____