

WARHURST FAMILY CHIROPRACTIC

CONFIDENTIAL PRACTICE MEMBER INFORMATION

Personal Information

Full name:		How Young are You?:		Date of Birth:	
Address:					
Street		City		State	Zip
Home phone:			Work phone:		
Cell phone:			Email address:		
Marital status: M S W D			Spouse/Guardian name:		
No. of children:			Is it Possible You are Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Height:	Weight:	Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much?			
Occupation & Employer's Name:					
Do you have insurance that will contribute to your care?			Do you have Medicare coverage?		
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Insurance Company:					

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is the problem (Check all that apply): Constant Intermittent Numbness Pins and Needles Dull Ache Sharp Burning
 Radiating Localized Better in the A.M. Better in the P.M. Better while active Better while sitting Better while laying

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition? _____

Is this condition interfering with any of the following?

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/Exercise <input type="checkbox"/>	Recreation/Play <input type="checkbox"/>	Walking <input type="checkbox"/>
Mental Function <input type="checkbox"/>	Concentration <input type="checkbox"/>	Sitting <input type="checkbox"/>	Eating <input type="checkbox"/>	Social Life <input type="checkbox"/>	Love Life <input type="checkbox"/>

Are you unable to do certain activities because of this pain, illness, condition? (i.e. sports, pick up grandchildren, etc.) If so, what?

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

General Health History

Have you had any surgery? (Please include all surgeries)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Diet

The type of diet I usually follow is classified as: _____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Maybe <input type="checkbox"/>

Exercise

Do you currently exercise regularly? Yes No What type & how often?

If you do not exercise regularly are you open to the idea of exercising on a consistent basis? Yes No Maybe

If specific exercises or stretching would help would you consider adding them to your program? Yes No Maybe

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) _____

Stressors

Often times, accumulation of life's stress can lead to health problems and absolutely influences our ability to heal. Please pay close attention to this as it will help us help you! Please list your top three stresses (you have ever had) in each category:

- Physical stress (slips/falls, accidents, work postures, sport/recreational injuries, traumas, repetitive motions, etc.)
 - _____
 - _____
 - _____
- Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, artificial sweeteners, etc.)
 - _____
 - _____
 - _____
- Psychological or mental/emotional stress (work, relationships, family, finances, self-esteem, deadlines, etc.)
 - _____
 - _____
 - _____

On a scale of 1-10 (1 being low and 10 being high) please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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If reducing stress would help you, would you like to know ways to reduce stress? Yes No Maybe

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your overall "quality of life"?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Is there anything else which may help to better understand you which has not been discussed?

Why are you here at this point in time?

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable. I also understand and agree that it is not the policy of Warhurst Family Chiropractic to extend credit. Any account that has an unpaid balance will be charged interest at the rate of 18% per year on any balance due over 30 days.

Print Patient Name: _____ Date: _____

Signature: _____

Signature of Parent/Guardian (for minor): _____

Warhurst Chiropractic
1010 Depot Hill Road, Suite 104
Broomfield, Co 80020
303-464-9282

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received Warhurst Chiropractic Notice of Privacy Practices written in plain language. The Notice provides information in detail the uses and disclosures of my protected health information that may be made by Warhurst Chiropractic, my individual rights and Warhurst Chiropractic's legal duties with respect to my protected health information. The Notice includes:

- A statement that Warhurst Chiropractic is required by law to maintain the privacy of protected health information.
- A statement that Warhurst Chiropractic is required to abide by the terms of the Notice currently in effect.
- Types of uses and disclosures that Warhurst Chiropractic is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which Warhurst Chiropractic is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and brief description of how I may exercise these rights in relation to:
 - The rights to complain to Warhurst Chiropractic and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory action will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information and that Warhurst Chiropractic is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from Warhurst Chiropractic upon request.

Warhurst Chiropractic reserves the right to the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain Warhurst Chiropractic's Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____