Member Health Record

ABOUT YOU

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

DATE OF BIRTH: | AGE:

GENDER:

MARITAL STATUS: | NUMBER OF CHILDREN:

EMPLOYER:

WORK PHONE: | EMPLOYER/POSITION TITLE:

How would you like appointment reminder: ❑ Email ❑Text —>Carrier____________

ABOUT YOUR SPOUSE

SPOUSE NAME:

SPOUSE EMPLOYER/POSITION:

POSITION TITLE:

YOUR CHILDHOOD YEARS

Question			
DID YOU HAVE ANY CHILDHOOD ILLNESSES?	❑ YES	❑ NO	❑ UNSURE
DID YOU HAVE ANY SERIOUS FALLS AS A CHILD	❑ YES	❑ NO	❑ UNSURE
DID YOU PLAY YOUTH SPORTS	❑ YES	❑ NO	❑ UNSURE
DID YOU TAKE / USE ANY DRUGS?	❑ YES	❑ NO	❑ UNSURE
DID YOU HAVE ANY SURGERY?	❑ YES	❑ NO	❑ UNSURE
HAVE YOU FALLEN/JUMPED FROM A HEIGHT OVER 3 FEET?	❑ YES	❑ NO	❑ UNSURE
WERE YOU INVOLVED IN ANY CAR ACCIDENTS AS A CHILD?	❑ YES	❑ NO	❑ UNSURE
WERE THERE ANY PROLONGED USE OF MEDICINE SUCH AS ANTIBIOTICS OR AN INHALER?	❑ YES	❑ NO	❑ UNSURE
DID YOU SUFFER FROM ANY OTHER TRAUMAS?	❑ YES	❑ NO	❑ UNSURE
WERE YOU VACCINATED?	❑ YES	❑ NO	❑ UNSURE
AS A CHILD, WERE YOU UNDER REGULAR CHIROPRACTIC CARE?	❑ YES	❑ NO	❑ UNSURE

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):
❑ Sign ❑ Google ❑ Community Event ❑ Website ❑ Other ____________

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

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S 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:

PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. IF YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE CHECK THE BOX AND SKIP TO THE NEXT PAGE:
❑ WELLNESS ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY
❑ JOB ❑ CHRONIC DISCOMFORT ❑ 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

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS: ❑ GOOD ❑ BAD ❑ INDIFFERENT

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

HEALTH HABITS

DO 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	❑ DIABETES
❑ STIMULANTS	❑ PAIN KILLERS/NARCOTICS
❑ ANXIETY/DEPRESSION	❑ BLOOD PRESSURE MEDICINE
❑ MUSCLE RELAXERS	❑ OTHER

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY SUFFER WITH THE SAME CONDITION?
IF YES THEN WHAT IS YOUR RELATIONSHIP

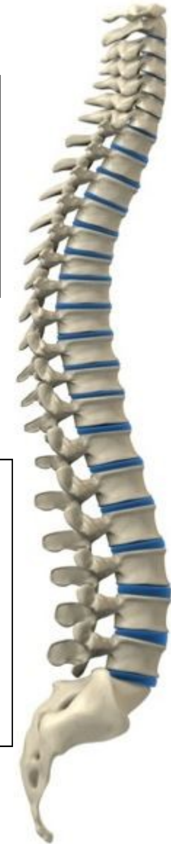
ARE THERE ANY HEREDETARY CONDITIONS IN YOUR FAMILY?

IS THERE ANY OTHER FAMILY HISTORY THAT THE DOCTOR SHOULD KNOW ABOUT?

YOUR CONCERNS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems



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 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.*

				FOR WOMEN ONLY
❑ SEVERE OR FREQUENT HEADACHES	❑ THYROID PROBLEMS	❑ PAIN IN ARMS/LEGS/ HANDS	❑ NUMBNESS	
❑ HEART SURGERY/ PACEMAKER	❑ SINUS PROBLEMS	❑ LOW BLOOD PRESSURE	❑ ALLERGIES	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ LOWER BACK PROBLEMS	❑ HEPATITIS	❑ RHEUMATIC FEVER	❑ DIABETES	IF YES, WHEN IS YOUR DUE DATE?
❑ DIGESTIVE PROBLEMS	❑ DIFFICULTY BREATHING	❑ ULCERS/COLITIS	❑ SURGERIES:	ARE YOU NURSING? ❑ YES ❑ NO
❑ PAIN BETWEEN SHOULDERS	❑ KIDNEY PROBLEMS	❑ TUBERCULOSIS	❑ ASTHMA	ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
❑ CONGENITAL HEART DEFECT	❑ HIGH BLOOD PRESSURE	❑ ARTHRITIS	❑ LOSS OF SLEEP	<u>*DO YOU:*</u> EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO HAVE IRREGULAR CYCLES? ❑ YES ❑ NO HAVE BREAST IMPLANTS? ❑ YES ❑ NO
❑ FREQUENT NECK PAIN	❑ CHEMOTHERAPY	❑ SHINGLES	❑ DIZZINESS	

❑ LIST ANY OTHER CONDITIONS OR DISEASES THE DOCTOR SHOULD BE AWARE OF:

❑ SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

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

DID YOU KNOW CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?

❑ YES ❑ NO

Patient Signature ________________ ***Date***________

Doctors Signature ________________ ***Date***________

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 with Chiropractic care.

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

HEALTHCARE AUTHORIZATION FORM

I have been offered to view a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. We encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Brown Family Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS: Brown Family Chiropractic will be referred to as "BFC" throughout the rest of this document.

- I give permission to BFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If BFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to BFC 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 or in ads in print media.
- I give BFC permission 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 doctor at any time in private, the doctor will provide a room for these conversations. **Please note: initial examinations and treatments are done in private rooms**
- By signing this form you are giving BFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Brown Family Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of BFC. The written notice must contain the following information: Your name, Social Security number and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and Your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by BFC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, BFC will not refuse to provide treatment however, it will not be possible for BFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since BFC will be unable to contact me 3) all contact with BFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge the offering and/or receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): ______________________________ DOB:_________________

Patient's Signature: ______________________________________ Today's Date: ________________________

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):____

Signature:____

INSURANCE POLICIES AND GUIDELINES

The purpose of this is to let you know how our office works in the handling of your insurance claims. We do this to eliminate any questions or misunderstandings that could arise and later affect your ability to use your policies as they were intended.

Insurance:

BFC will verify and file your insurance as a service to you. If we are not In -Network with your carrier, you may have Out-of-Network benefits. You will be informed of your coverage at your Report of Findings. The charges billed to the carrier depend on the individual needs of each patient. We know that there are a lot of charges that will not be paid for various reasons and we expect to receive denial on some claims because it is the nature of the insurance industry. Most insurance companies decide for you what is medically necessary, regardless of our recommendations or your health desires. Please refer to your insurance plan's policies if you have questions regarding medical necessity vs. clinical recommendations. Insurance only covers short-term, acute, active care—it does not cover corrective, wellness or maintenance care.

The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balance due. If our office does not hear from your insurance company within 30 days, we will request your help in contacting your insurance company to resolve the payment delay. It is your responsibility to make sure that copies of any and all correspondences from your carrier be given to us.

Payment of Services:

I understand I am financially responsible for all charges and fees related to the services rendered to me by BFC. I further understand that the payment in full is expected at time of service, which may include copayments, deductibles and any services not covered by insurance.

Assignment of Benefits:

I hereby authorize payment directly to the center by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer. If your insurance company sends the payment directly to you instead of mailing it to our office, we ask that you bring the payment to us, to save us from billing you later.

No Insurance Coverage:

If you do not have insurance coverage or choose not to bill your carrier, we can pass an administrative savings along to you. Since we do not incur the overhead involved with insurance billing, we are able to pass along a savings so you can receive all care necessary at an affordable fee.

Patient name (print): ______________________________________ Date: _____________

Patient (parent) Signature __________________________________