genesis
FAMILY CHIROPRACTIC
Where true health begins.

Grown-Up Health Record

ABOUT YOU

Patient Name:							Date of Birth:					
Address:												
City:		State/Zip:					Email Address:					
Primary Phone:							Secondary Phone:					
Cellular Phone Carrier (e.g., Spring, Verizon, AT&T):												
Employer Name:												
Employer Address:												
Position/Title:												
Type of work performed:												
Marital Status:	Single		Married		Separated			Divorced			Widowed	
Spouse's Name:							Anniversary:					
Children (Names & Ages):												

ON A SCALE OF 1-10, PLEASE RATE YOURSELF BELOW

Your interest in reducing stress:	Weak	1	2	3	4	5	6	7	8	9	10	Strong
Getting fit:	Weak	1	2	3	4	5	6	7	8	9	10	Strong
Improving posture:	Weak	1	2	3	4	5	6	7	8	9	10	Strong
Improving mobility:	Weak	1	2	3	4	5	6	7	8	9	10	Strong
Improving sleep:	Weak	1	2	3	4	5	6	7	8	9	10	Strong
Improving quality of life:	Weak	1	2	3	4	5	6	7	8	9	10	Strong

How did you learn of our office?

Has any member of your family ever seen a chiropractor? Y N

If yes, please tell us about your/their experience:

REASON FOR THIS VISIT

What brings you in today?

Wellness Condition

If condition, please describe:

What are your major health concerns? When did you first notice these issues?

Concern	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Let the favor of the Lord our God be upon us, and establish the work of our hands upon us; yes, establish the work of our hands! Psalms 90:17

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Over time, has/have the issues/concerns:
Gotten worse Stayed constant Come and gone

How has this issue affected your life? Please explain.

Please list any traumas, major injuries, surgeries or hospital stays with approximate dates.

Have you been in a motor vehicle accident? yes no
If so, please describe the incident including the date(s).

Have you ever participated in any high impact/contact type sports (e.g., soccer, football, martial arts, etc.)?
yes no
Please explain:

YOUR HEALTH HISTORY

INSTRUCTIONS: *Please circle each of the diseases or conditions that you have ever experienced. While they may seem unrelated to the purpose of this appointment, they can affect the overall assessment, care plan and possibility of being accepted for care.*

Abnormal blood sugar	Acid reflux	Allergies/sinus problems	Anxiety	Asthma
Back pain/stiffness	Bad breath	Blood pressure (high or low)	Buzzing/ringing in ears	Cholesterol (high or low)
Cold feet	Cold hands	Cold sweats	Constipation or diarrhea	Depression
Difficult/painful/ irregular periods	Dizziness or loss of balance	Fainting	Fatigue	Fever
Frequent colds, coughs, etc.	Headaches	Heartburn	Hip/knee/ankle pain	Hot flashes
Infertility	Irritability	Lights bother eyes	Loss of smell or taste	Mood swings
Neck pain/stiffness	Nervousness	Numbness/tingling in arms/hands	Numbness/tingling in legs/feet	Ringing in ears
Shoulder/elbow/wrist pain	Sleeping problems	Stress or tension	Ulcers	Upset stomach
Urinary tract infection	Impulsiveness	Easily distracted	Disorganized	Lacking motivation
Poor concentration	Spaciness	Low pain threshold	DIfficulty waking up	Worry
Teeth grinding	Heart palpitations	Restless sleep	Poor expression of emotions	Poor immune system
Racing mind	Sleepwalking	Food sensitivities	Eating disorders	Bipolar disorder
Panic attacks	Migraines	Vertigo	Seizures	Bed wetting

Describe your typical meal for:
Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Approxiately how much water do you drink daily? _____

Do you drink soda? Yes No
How much per day? _____ Per week? _____

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Please list any supplements or prescriptions you are currently taking, the dosages of each, and how long you have been taking them. (If you need more space, please write on the back of this page.)

Supplement/Prescription	Dosage	How long taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe your bowel movements and urine:

	Bowels	Urine
Frequency	_____	_____
Color	_____	_____
Consistency	_____	

Please circle "y" for yes, "s" for sometimes, and "n" for no.

I love myself.....	Y	S	N
I am satisfied with my life.....	Y	S	N
I enjoy my job.....	Y	S	N
I tend to have great relationships.....	Y	S	N
I am a steward of my own health and well-being.....	Y	S	N
I spend time in prayer and/or meditation on a daily basis.	Y	S	N
I adapt well to change.....	Y	S	N
I listen to my body's messages.....	Y	S	N
I actively practice stress management.....	Y	S	N
I have a regular exercise schedule.....	Y	S	N
I experience periods of prolonged sadness.....	Y	S	N
I speak/read/write affirmations.....	Y	S	N

LIFESTYLE HEALTH HISTORY

Describe your childhood home:

Describe your childhood activities that may have caused your body stress (e.g., sports, daredevil tendencies, music lessons [i.e., violin], etc.)

How many siblings do you have? _____ What is your birth order? _____

Please circle all that apply to your current lifestyle.

Enjoy regular time with nature	Extended periods of sitting/standing	Labor intensive
Regular detox/cleansing	Reading ingredient labels	Community involvment
Travel often	Financially stressed	High-stress responsibilities

How much exercise do you get in a typical week? _____
What are your primary methods of exercise (yoga, cardo, weights, etc.)? How frequently for each?

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INSTRUCTIONS: *On the diagram in the column to theright, place an X where you believe your health is right now and a ✓ where you would like your health to be.*

How long do you think it will take to get to where you circled in the diagram on the right?

_____

What might you need to change to help you reach your goal?

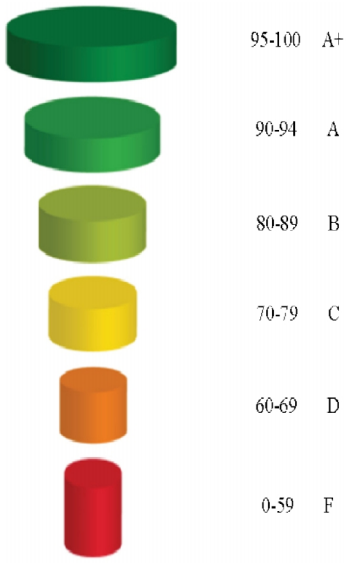
_____

_____

_____

_____

_____



FOR FEMALES ONLY

Do you have menstrual pains? Y N Pain during: cycle ovulation

When was your first menses? _____ Number of pregnancies? _____

Have you had a cesarean birth ? Y N

Did you have complications with any of your pregnancies or deliveries?

Have you begun menopause? Y N
Have you completed menopause? Y N
Describe your transition through menopause.

To the best of my knowledge, at present, I am not pregnant and I hereby release Genesis Family Chiropractic and radiological staff from any responsibility or liability upon my being x-rayed for the purpose of diagnostic evaluation.

_____ _____
Patient signature Date

GOALS AND EXPECTATIONS

If you could improve one thing about your health, what would it be?

What thing(s) related to your health and wellness would you like to accomplish?

If we could make recommedations that would not only address your main concerns, but could also help you with improving your overall health, would you like to hear them? Y N

STAGES OF CARE

There are three stages of chiropractic care. Please initial in the space beside the type of care you are seeking.

_____	Relief care (eliminate my symptoms only)
_____	Corrective care (eliminate the underlying issue in hope of correction, and reduce the likelihood of reoccurrence)
_____	Wellness care (optimize the function of my body's systems in order to live a more vibrant life)
_____	Let the doctor choose the level of care that is most appropriate for me.

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Patient Policies

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorizationis strictly limited to defined situations that include emergency care, quality assurance activities, public health, research,andlaw 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 review 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 the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privace 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 qulity 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:

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 understands both the objective and the method that they 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 spine. This can cause alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum 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, 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 statements. 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:

Appointment Policy

Appointments with Genesis Family Chiropractic are scheduled according to the program of care that the doctor feels is best for you. This customized program will consist of three stages: relief care (relief from pain), corrective care (maintaining stability), and wellness care (prevention). Depending on where you begin, multiple adjustments will be scheduled for you in a concentrated amount of time, followed by re-evaluations to monitor your progress. As you improve and your health stabilizes, you will be promoted into the next stage of care.

After completion of the initial program, a consultation will be scheduled to re-evaluate your stage of care and to outline a new, customized program including health goals, accountability, and wellness education.

If you are unable to keep an appointment, we require that you inform us with 48-hours notice. Genesis Family Chiropractic reserves the right to charge $50.00 for missed appointments or for those appointments cancelled without a 48-hour notice. **In order to achieve your best results, every cancelled appointment must be made up.**

Following the schedule that your doctor outlines for you is of paramount importance. We ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results.

When entering the office on any given visit, please stop by the front desk to check-in. Once you have checked in, you may then proceed to any open adjusting table (if available) or one of the "hot-seats" in anticipation of the next available table. We strive to honor all appointments at the scheduled time. If you are late, or expect to be late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. If you have any questions regarding our office, policies or your appointments please do not hesitate to ask.

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Signature:	Date:

Consent for Chiropractic Examination

I hereby give my consent to a professional and complete chiropractic examination and to any x-ray examination that the doctor deems necessary. I understand and agree that payments to this office for x-rays are for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. I understand that all services are to be paid-in-full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition using 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. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

Signature:	Date:

Office Use Only