



It is our pleasure to be of service to you. Please fill out our confidential Patient Health Record completely and accurately.

Studer Chiropractic is dedicated to removing nerve interference by hand to restore and maintain optimum health.

Through education we promote a lifetime of health, strength, and vitality.

We envision chiropractic care for every man, woman and child to build a healthier community and world.

ADULT HISTORY

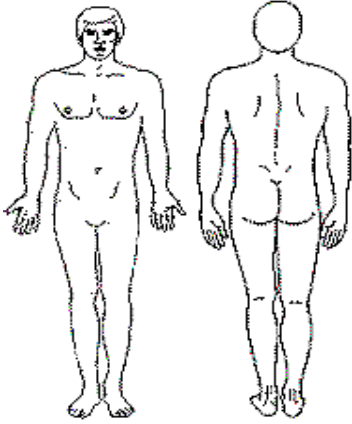
ABOUT THE PATIENT

Name _____ Birth Date _____
 Address _____ City _____ State _____ Zip _____
 Phone: H _____ C _____ W _____
 Employer _____ Type of work _____
 Marital Status Mar. Sing. Div Wid. Spouse's name _____
 Children's names and ages _____

 Email Address _____
 Would you like us to email you our monthly newsletter? Yes No

REASON FOR THIS VISIT

Describe the purpose of this visit _____

 Is the purpose of this appointment related to Job Auto Fall
 Sports Daily Life Chronic Discomfort Other
 When did this health challenge begin? _____
 Does this interfere with Work Sleep Daily Routine
 Other Activities Explain _____
 Using the diagram to the right please indicate with an X where your
 problems are occurring → 
 Have you seen other professionals for this? Yes No
 Dr.'s Name (s) _____
 Type of Treatment _____
 Results _____
 What are your objectives in consulting us? _____
 What are your health goals once these objectives have been met? _____

 What other wellness professionals are currently a part of your health care team?
 Massage therapist Acupuncturist Naturopath Homeopath Other _____

Were 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
- ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

GOALS FOR MY CARE

Which best describes your reason for consulting our office?

I am only concerned about relief of a particular symptom.
 I am only concerned about relief of a particular symptom, and preventing its return.
 I want optimum health and wellbeing on every level available to me.

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____
 Have you been adjusted by a Chiropractor before? Yes No
 Reason for those visits? _____
 Previous Chiropractor's Name _____
 Approximate Date of Last Visit _____
 Approximate Date of Last X-ray _____
 Has any adult in your family seen a Chiropractor? Yes No
 Has any child in your family seen a Chiropractor? Yes No

MEDICATIONS I NOW TAKE

- | | |
|---|---|
| <input type="checkbox"/> Stomach Medications | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Pain Killers (including aspirin) | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Anxiety/depression |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Hormone Therapy |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Cholesterol |
| | <input type="checkbox"/> _____ |

HEALTH HABITS

Do you....	No	Yes (please explain)
Smoke?	<input type="checkbox"/>	<input type="checkbox"/> _____ packs/day
Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/> _____ drinks/week
Drink coffee/soda?	<input type="checkbox"/>	<input type="checkbox"/> _____/day
Exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/> _____
Take any supplements?	<input type="checkbox"/>	<input type="checkbox"/> _____ _____

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has 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.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low energy | <input type="checkbox"/> Shingles | For Women:
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience painful periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have irregular cycles? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Kidney problems | |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Chemotherapy | |
| <input type="checkbox"/> Pain between the shoulders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety/Depression | |
| <input type="checkbox"/> Numbness or pain in arms/legs/hands | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Thyroid problems | |
| <input type="checkbox"/> Lower back problems | <input type="checkbox"/> Lowered immune system | <input type="checkbox"/> Heart attack | |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Carpal Tunnel | |
| <input type="checkbox"/> Ulcers/colitis | <input type="checkbox"/> Irregular Bowel | <input type="checkbox"/> Fibromyalgia | |
| | | <input type="checkbox"/> Other _____
_____ | |

Are you healthier now than you were 5 years ago? Yes No If yes, what did you do to accomplish this? _____

If no, why do you think your health has deteriorated over the last 5 years? _____

Will you be healthier 5 years from now than you are today? Yes No

Why or why not? _____

What would you like your health to be 5 years from now? _____

How many Medical Doctor's office visits did you and your family have last year?

- None Less than 5 More than 5 More than 10 More than 20 Too many

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of **vertebral subluxations**. Stress that may be physical, chemical or emotional may cause these **subluxations**. The practice of chiropractic is based on the location and reduction of nerve system interference caused by the **vertebral subluxations**.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following.

PLEASE TELL US ABOUT ANY STRESS RELATED TO YOUR BIRTH:

	No	Yes	Explain:
• Drugs/medicine/tobacco/alcohol in pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Labor chemically induced?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Forceps/Vacuum Extraction/C-section?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Premature delivery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Vaccinations?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Falls in first year of life?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Any health related problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE TELL US ABOUT ANY STRESS DURING YOUR CHILDHOOD:

	No	Yes	Explain:
• Any falls or injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Allergy/Asthma or Respiratory problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Ear Infections?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Digestive Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Hyperactivity?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Any other health related problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE TELL US ABOUT ANY STRESS UP TO THE PRESENT:

	No	Yes	Explain:
• Auto Injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Work Injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Sports Injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Work Stress?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Family/Home Stress?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Prescription Drug Use?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Ever Hospitalized/Surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Recurring Illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Limited Exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Poor Nutrition?	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Other Health Issues?	<input type="checkbox"/>	<input type="checkbox"/>	_____

AUTHORIZATION FOR CARE

I hereby authorize Studer Chiropractic P.C. and its Doctors to administer care as they deem necessary. 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 will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Studer Chiropractic P.C. will be credited to my account on receipt.

Patient or Guardian Signature: _____ Date: _____



Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records for a fee at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Signature

Date