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.

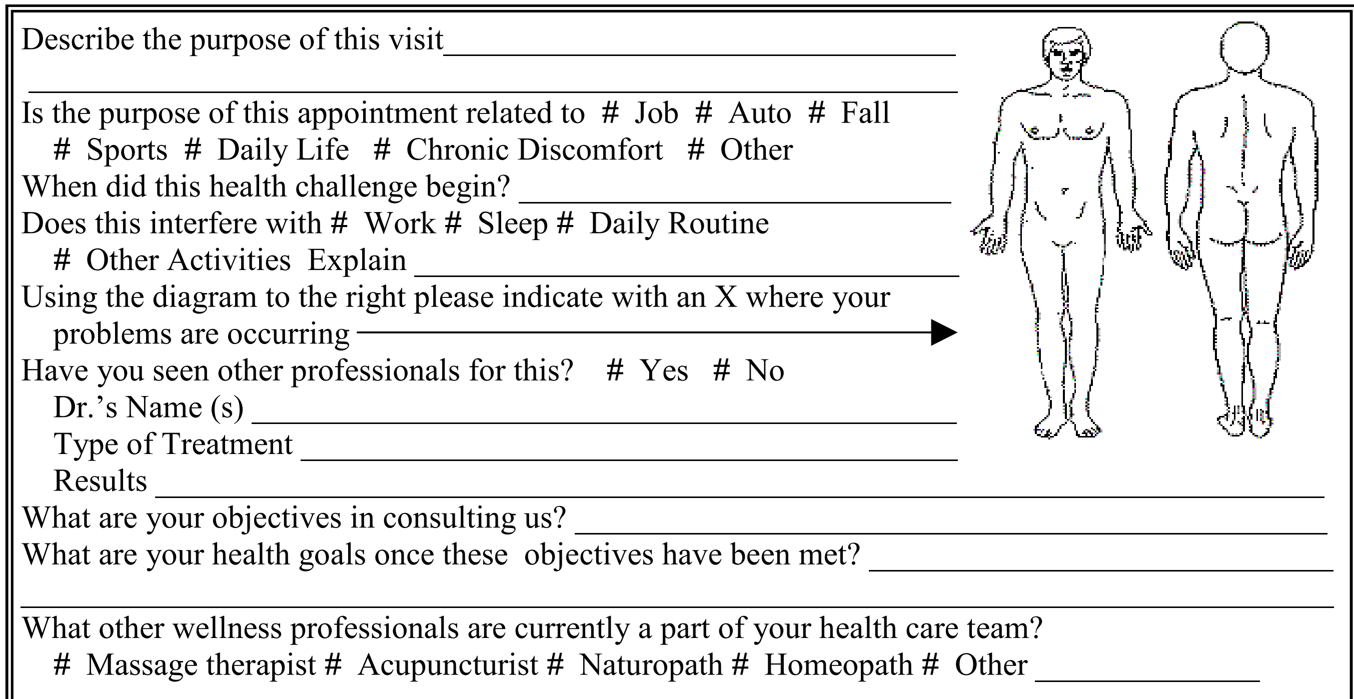
We envision chiropractic care for every man, woman and child to build a healthier community and world.

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

Stomach Medications
Pain Killers (including aspirin)
Muscle Relaxers
Blood Pressure
Insulin
Stimulants
Blood Thinners
Anxiety/depression
Hormone Therapy
Cholesterol
____

HEALTH HABITS

Do you….	**No**	**Yes (please explain)**
Smoke?		____ packs/day
Drink alcohol?		____ drinks/week
Drink coffee/soda?		____/day
Exercise regularly?		_______________
Take any supplements?		_______________
		_______________

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.

Headaches
Allergies
Sinus problems
Dizziness
Loss of sleep
Pain between the shoulders
Frequent neck pain
Numbness or pain in arms/legs/hands
Lower back problems
Digestive problems
Ulcers/colitis

Low energy
Heart surgery/ pacemaker
Heart murmur
High/low blood pressure
Difficulty breathing
Asthma
Arthritis
Alcohol/drug abuse
Lowered immune system
Diabetes
Irregular Bowel

Shingles
Kidney problems
Hepatitis
Cancer
Chemotherapy
Anemia
Anxiety/Depression
Thyroid problems
Heart attack
Carpal Tunnel
Fibromyalgia
Other ____________
____

For Women:
Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking birth control pills? Yes No
Do you experience painful periods? Yes No
Do you have irregular cycles? Yes No

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?			______________________
• Labor chemically induced?			______________________
• Forceps/Vacuum Extraction/C-section?			______________________
• Premature delivery?			______________________
• Vaccinations?			______________________
• Falls in first year of life?			______________________
• Any health related problems?			______________________

PLEASE TELL US ABOUT ANY STRESS DURING YOUR CHILDHOOD:

	No	Yes	Explain:
• Any falls or injuries?			______________________
• Allergy/Asthma or Respiratory problems?			______________________
• Ear Infections?			______________________
• Digestive Problems?			______________________
• Hyperactivity?			______________________
• Any other health related problems?			______________________

PLEASE TELL US ABOUT ANY STRESS UP TO THE PRESENT:

	No	Yes	Explain:
• Auto Injuries?			______________________
• Work Injuries?			______________________
• Sports Injuries?			______________________
• Work Stress?			______________________
• Family/Home Stress?			______________________
• Prescription Drug Use?			______________________
• Ever Hospitalized/Surgeries?			______________________
• Recurring Illnesses?			______________________
• Limited Exercise?			______________________
• Poor Nutrition?			______________________
• Other Health Issues?			______________________

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