nexus
FAMILY CHIROPRACTIC

File _____

PERSONAL HEALTH HISTORY

Welcome to Nexus Family Chiropractic. Please fill out this form to the best of your ability to help speed up your office visit, and to allow us to better serve your healthcare needs. If there are any sections that do not apply, simply write "N/A" and move on to the next section

Date _____

Name _____Guardian (if under 18 years) _____

Date of Birth _____ Age _____ Social Security # _____

Address _____ City _____ State ____ Zip _____

Phone (H) _____ (W) _____ (C) _____ Cell Provider _____

E-mail _____ Occupation _____

Employer _____ Marital Status ❒ S ❒ M ❒ D ❒ W

Spouse's Name _____ Spouse's Occupation _____

Whom can we thank for referring you to our office? _____

Emergency Contact: Name _____ Relationship _____ Phone _____

Number of Children and Ages

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Previous Chiropractic Care?

Yes___ No___ Reason _____

Yes___ No___ Reason _____

Yes___ No___ Reason _____

Yes___ No___ Reason _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

Health Care Practitioner History

Have you ever received chiropractic care? ❒ Yes ❒ No Name of D.C. _____

Reason for care _____ How long? _____ Date of last visit _____

How did you respond with care? _____

Have you ever consulted or do you regularly consult with any of the following providers for care?

Check all that apply: ❒ Naturopath ❒ Acupuncturist ❒ Homeopath ❒ Energy Healer

❒ Psychotherapist ❒ Massage Therapist ❒ Other

Primary care provider name _____ Date of last visit _____

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Reason for Seeking Chiropractic Care

Do you have a present Complaint or Concern? If no current complaint, what is the reason for your visit today?

_____

When did this condition begin? _____

Is the condition: ❒ Getting Worse ❒ Improving ❒ Constant ❒ Intermittent ❒ Unsure

How did the condition start? ❒ Suddenly ❒ Gradually ❒ Post-Injury ❒ Auto Accident

What makes the condition better? _____

What makes the condition worse? _____

Is condition worse during certain times of the day? ❒ No ❒ Morning ❒ Afternoon ❒ Evening ❒ Night

Have you ever had a similar condition before? ❒ Yes ❒ No Please explain _____

Is this condition interfering with: ❒ Work ❒ Sleep ❒ Daily Routine ❒ Hobbies ❒ Exercise

If so, please explain _____

Who have you seen for this condition? _____

How did you respond? _____

Please check if you currently have or have had any of the following conditions:

❒ Asthma	❒ Depression	❒ Hernia	❒ Poor Posture
❒ Allergies	❒ Diabetes	❒ High Blood Pressure	❒ Prostate Trouble
❒ Anxiety or Nervousness	❒ Digestive Problems	❒ Irregular Menstrual Cycle	❒ Sensitive to Light
❒ Autoimmune Disease	❒ Dizziness	❒ Irritability	❒ Shortness of Breath
❒ Blurred Vision	❒ Ears Ring	❒ Kidney Stones	❒ Sleeping Problems
❒ Cancer	❒ Fainting	❒ Loss of Balance	❒ Stomach Ulcer
❒ Chest Pains	❒ Fatigue or Low Energy	❒ Loss of Memory	❒ Stroke
❒ Cold Feet or Hands	❒ Gout	❒ Loss of Smell or Taste	❒ Tendonitis
❒ Cold Sweats	❒ Heart Burn	❒ Numbness Fingers/Toes	❒ Thyroid Condition
❒ Constipation/Diarrhea	❒ Heart Problems	❒ PMS	❒ Urinary Frequency

Please list any prescription drugs you are taking? _____

_____ Have you had surgery ❒ Yes ❒ No Please explain what type and when _____

_____

What side effects have you experienced from the drugs and surgery? _____

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SOCIAL & LIFESTYLE HABITS, & FAMILY HISTORY

Your Birth Process

What was YOUR birth process like? ❒ Vaginal ❒ Medications ❒ Forceps ❒ Caesarian ❒ Breach ❒ Episiotomy ❒ Epidural ❒ Induced ❒ Home or water birth ❒ Vacuum extraction

Your Growth and Development

Did you ever once… ❒ Learn to care for your spine ❒ Fall out of bed ❒ Breastfeed ❒ Have surgery ❒ Take drugs ❒ Fall while learning to walk ❒ Get spanked ❒ Fall down stairs ❒ Pulled by your arm

Current Health Habits

Do you smoke? ❒ Yes ❒ No How often? ❒ Daily ❒ Weekends ❒ Occasional

Do you drink alcohol? ❒ Yes ❒ No How often? ❒ Daily ❒ Weekends ❒ Occasional

Do you exercise? ❒ Yes ❒ No How often? ❒ 1-2x/week ❒ 3-4x/week ❒ 5x or more/week

Please list the type of exercise(s) _____

Do you eat healthy? ❒ Yes ❒ No How often? ❒ 1-2x/week ❒ 3-4x/week ❒ 5x or more/week

Have Teeth problems ❒ Yes ❒ No Have Eye problems ❒ Yes ❒ No Have Hearing problems ❒ Yes ❒ No

How many hours do you sleep a night? ❒ Less than 5 hours ❒ 5-7 hours ❒ 7-9 hours ❒ More than 9 hours

Rate the stress regarding your life in general ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ Very Low

Rate your current stress level regarding work ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ Very Low

Rate your current stress regarding finances ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ Very Low

Rate your current stress regarding relationships ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ Very Low

How would you rate your physical health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

How would you rate your mental/emotional health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

How would you rate your overall quality of life? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Female History

Please list your number of Pregnancies _____ Vaginal Deliveries _____ Cesarean Surgery _____ Miscarriages _____

Deliveries were at ❒ Home ❒ Birth Center ❒ Hospital ❒ Other _____

Have you ever taken birth control medication? ❒ Yes ❒ No Have you ever had infertility issues? ❒ Yes ❒ No

Date of last menstrual cycle _____

Male History

Have you ever experienced infertility issues with your spouse? ❒ Yes ❒ No Date of last prostate exam _____

Erectile dysfunction? ❒ Yes ❒ No Difficulty/pain during urination? ❒ Yes ❒ No

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Family History

	Heart Disease	Arthritis	Cancer	Diabetes	Stroke
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Your oldest grandparent on record lived to the age of _____.

❒ Still living ❒ Deceased

Expectations of Care

What are your personal and family's health goals?

_____

_____

_____

How do you expect to achieve these goals?

_____

_____

_____

Is there anything else you'd like to discuss with the Doctor today that you have not listed previously?

_____

_____

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

- ❒ Feel better quickly
- ❒ Correct the cause of a problem as well as relief
- ❒ Prevent future problems
- ❒ Live a healthier lifestyle
- ❒ Healthier spine and nervous system
- ❒ Optimal health on all levels

Thank you for trusting us at Nexus Family Chiropractic to connect you and your family to health, happiness, and longevity.

_____ _____

Signature Date

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: 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 of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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 is called, 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 subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All 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

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Consent to Care

I do hereby authorize the doctor of Nexus Family Chiropractic to administer chiropractic care that is necessary for my particular case. This may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also clearly understand that if I do not follow the doctors specific recommendations at Nexus Family Chiropractic that I will not receive the full benefit from the services, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I understand that payment for care is out-of-pocket and paid before or directly after services are rendered. If I wish to obtain reimbursement from my health insurance company, Nexus Family Chiropractic will supply the proper documentation necessary to receive reimbursement for services. Nexus Family Chiropractic is not liable for any lack of reimbursement from my health insurance company.

I have read, understand, and hereby request chiropractic care based on the terms of acceptance and the consent to care.
Your Name: (Printed) _____

Signature _____ Date: _____

Healthcare Authorization

The following authorizes Nexus Family Chiropractic to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give permission to Nexus Family Chiropractic to use my name, address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, health related-emails and information about treatment alternatives or other health related information, as well as my advertisements, newsletters, or patient of the week/month postings.

I give permission to Nexus Family Chiropractic 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 protective health care information during my treatment. Should I need to speak with a doctor in private, the doctor will provide a private room for these conversations.

By signing the following you are giving Nexus Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges: * The right to review the notice prior to signing this consent * The right to object to the use of my health care information for directory purpose * The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations