thrive CHIROPRACTIC

ID#_____

Name:_____ Today's Date:_____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Cell: ( )_____Email Address:_____
Male: ____ Female: ____ Birth Date: _____/_____/_____ Age: _____ □ Single □ Married

Occupation: _____ Employer: _____

Have you seen a Chiropractor before? Yes No If yes, when? _____

T-Shirt Size: S / M / L / XL / XXL

Whom may we thank for referring you to our office?

YOUR HEALTH HISTORY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problems.

___ Headaches	___ Ear Infections	___ Kidney Problems	___ Numb/Tingling	___Fibromyalgia
___ Migraines	___ Hearing Loss	___ Menstrual Problems	___ Jaw/TMJ Pain	___Arthritis
___ Neck Pain	___ Stroke	___ Dizziness	___ Asthma	___Bladder Problems
___ Mid Back Pain	___ Shoulder Pain (L/R)	___ Fatigue	___ Infertility	___ Elbow/Wrist Pain
___Low Back Pain	___ Vertigo	___ Seizures	___ High/Low Blood Pressure	___Allergies
___Gastric Reflux	___ Heart Attack	___ Anxiety	___ Thyroid Disorder	___ Skin Problems
___ ADD/ADHD	___ Disc Problems	___Knee Pain (L/R)	___ Hip/Leg Pain (L/R)	___ Depression
___ Constipation	___ Scoliosis	___ Sciatic Pain (L/R)	___Foot Pain (L/R)	___Diabetes (1 or 2)

Main Complaint:_____

List any medications you are taking: _____

Have you been in a car accident recently? Yes No If so, when? _____

Have you ever had or currently have cancer? Yes No If so what kind and when? _____

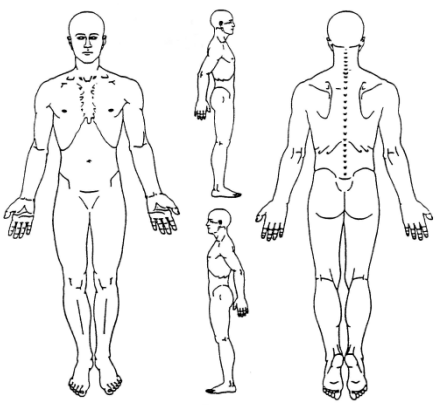
Have you had any previous surgeries? Yes No If so, when and what? _____

_____

Social History

1. Smoking: How often? □ Daily □ Weekends □ Occasionally □ Never
2. Alcohol: How often? □ Daily □ Weekends □ Occasionally □ Never
3. Exercise: How often? □ Daily □ Weekends □ Occasionally □ Never

***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are a part of your life:

ACTIVITY:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Objects	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting for Long Periods	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing for Long Periods	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Outcome Assessment Tool

Please **circle** the number that best describes the question asked for your **MAIN COMPLAINT.**

EXAMPLE:

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 (8) 9 10

1. How would you rate your pain **RIGHT NOW?**

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or **AVERAGE** pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its **BEST**? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its **WORST**? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signature: _____ **Date:** _____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, this will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care, and give consent to the examination and chiropractic care that the doctor deems necessary, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Kristin Drumheller, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for all charges not covered.

Print Name: _____

Signature: _____ **Date:** _____

If This Health Profile Is for A Minor/Child, Please Fill Out and Sign Below

Written Consent for A Child

Name of Practice Member who is a Minor/Child: _____

I authorize Dr. Kristin Drumheller and any and all Thrive Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Thrive Chiropractic.

Guardian Signature: _____ **Date:** _____

Relationship to Minor/Child: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays. Digital x-rays on a CD will be available within 72 hours of any regular practice hour day. Please note**:** X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Thrive Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.
Print Full Legal Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Thrive Chiropractic. Date of Last Menstrual Cycle: ___/___/____
Signature: _____ **Date:** _____