ADULT CHIROPRACTIC HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
GENDER:	
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER:	
EMPLOYER NUMBER:	OCCUPATION:

ABOUT YOUR SPOUSE

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:

HEALTH HABITS

DO YOU SMOKE?	YES	NO
DO YOU DRINK ALCOHOL?	YES	NO
DO YOU DRINK COFFEE, TEA, OR SODA?	YES	NO
DO YOU EXERCISE REGULARLY?	YES	NO

DO YOU WEAR:

☐ HEEL LIFTS ☐ SOLE LIFT ☐ INNER SOLES ☐ ARCH SUPPORT

MEDICATIONS YOU TAKE

☐ CHOLESTEROL MEDICATIONS	☐ INSULIN
☐ STIMULANTS	☐ PAIN KILLERS
☐ TRANQUILIZERS	☐ BLOOD PRESSURE MEDICINE
☐ MUSCLE RELAXORS	☐ OTHER

Infinity Wellness Center
4716 4th Street Suite 102
(806)224-0063
Lubbock, TX 79416

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ☐ YES ☐ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITIS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
WHEN DID THIS CONCERN BEGIN?
HAS THIS CONCERN: ☐ GOTTEN WORSE ☐ STAYED CONSTANT ☐ CAME AND GONE
DOES THIS CONCERN INTERFERE WITH: ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONCERN OCCURRED BEFORE? ☐ YES ☐ NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN ? ☐ YES ☐ NO
DOCTORS NAME:
TYPE OF TREATMENT:
RESULTS: ☐ GOOD ☐ BAD ☐ INDIFFERENT
SURGERIES: _____

SUPPLEMENTS YOU TAKE

☐ ESSENTIAL FATTY ACIDS	☐ PROBIOTIC
☐ MULTIVITAMIN WHICH:_____	☐ VITAMIN D3
☐ CALCIUM / MAGNESIUM	☐ OTHER _____
☐ VITAMIN C	☐ OTHER _____

FOR WOMEN ONLY

WHEN THE FIRST DAY OF YOU R LAST MENSTRUAL CYCYLE?
_____

ARE YOU PREGNANT? ☐ YES ☐ NO ☐ UNSURE

IF YES, WHEN IS YOUR DUE DATE?

ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU TAKING BIRTH CONTROL? ☐ YES ☐ NO

HAVE YOU HAD A HYSTERECTOMY OR TUBAL ☐ YES ☐ NO

DO YOU:
EXPERIENCE PAINFUL PERIODS? ☐ YES ☐ NO
HAVE I RREGULAR CYCLES? ☐ YES ☐ NO
HAVE BREAST IMPLANTS? ☐ YES ☐ NO

I have completed the pregnancy questionnaire above truthfully and understand that I should not have x-rays if I could be pregnant. I authorize Infinity Wellness Center to perform diagnostic x-rays to help develop a treatment plan. I understand and agree that Infinity Wellness Center is released from all liability and litigation pertaining to myself and my unborn child.

Signature_____ Date:_____

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief care:** Symptomatic relief of pain or discomfort,

☐ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptoms.

☐ **Comprehensive care:** Bringing whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

☐ ***I want the doctor to select the type of care appropriate for my condition.***

YOUR CONCERNS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

WERE YOU AWARE THAT...

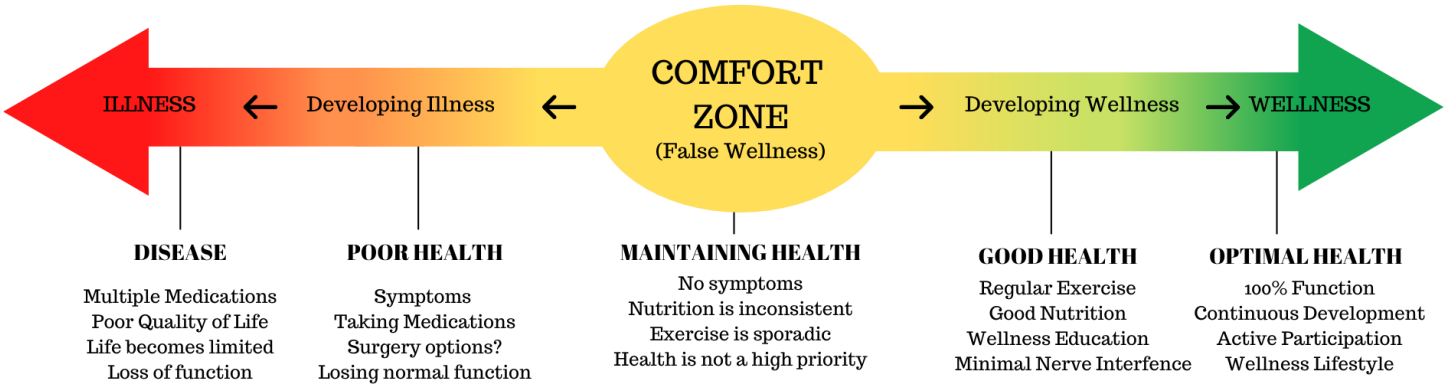
DOCTORS OF CHIROPRACTIC WITH THE NERVOUS SYSTEM?
☐ YES ☐ NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?
☐ YES ☐ NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ☐ YES ☐ NO

Rate your health :

Place an **'X'** that denotes where you believe your current level of health to be.
Place an **'O'** indicating where you would like your health to be.



Journey to Wellness

AUTHORIZATION FOR CARE

I hereby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to 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 that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. 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 the Doctor's Office will be credited to my account on receipt.

***Ownership of X-ray Films:** It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

INITIAL IF READ ABOVE: _____

TERMS OF ACCEPTANCE

When accepting a new client who is seeking chiropractic, A.M.I.T, pulse, Class IV laser, dry needling, cupping, and/or acupuncture, it is essential for both the client and the doctor to be working towards the same objective. Chiropractic has only one goal to work toward the cause, not the effect. It is only when the client 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 in the body. This can cause pain or alteration of nerve function and interference of the transmission or 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 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 subluxation.

I have read and fully understand the above statement. 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.

INITIAL IF READ ABOVE: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law 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 you records within 30 days with a request.
- You may request to view 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, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy 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 quality assessments and physician's certifications.*
- *You may request super bill, documentary of visits by email.*

I have read and understood 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 (if minor):
SIGNATURE:	DATE:

INFINITY WELLNESS CENTER
Chiropractic & Acupuncture