LEGACY
FAMILY CHIROPRACTIC

ADULT HISTORY FORM

Personal Information

Legal Name: _____ Date: _____/_____/_____

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

Cell Phone: _____ Other Phone: _____

Birth Date: _____/ _____/_____ Please circle one: Male / Female Married / Single / Widowed / Divorced

How did you hear about us? _____ Email: _____

Number of Children: ____ Names of other family members: _____

Insurance Information

(Please give your insurance card and driver's license to the front desk for a complimentary benefits evaluation)

Primary Insurance Carrier: _____ Subscriber's Name: _____

Occupation: _____Employer: _____

Birth Date: ____/_____/_____

Chiropractic Services Provided

- **Consultation-**includes practice member history. This service is complimentary.
- **Examination (new patient or established patient)-**includes one of more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check.
- **Chiropractic Adjustment –** The actual re-alignment of the vertebra. A specific instrument is used to make the spinal adjustment. 1 to 3 specific adjustments will be made per visit, re-aligning the vertebra.
- **X-rays –** Specific x-ray views taken of your spine to determine a misalignment/subluxations of your vertebrae. These can also be used to indicate progress after period of care.

****All charges will be reviewed and authorized by practice member before any charges are rendered.**

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to the doctors. 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 patient. 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 charges not covered by this assignment.

Signed _____ Date _____

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Initials: _____ Date: _____

Confidential Practice Member Information

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Who or what may we thank for referring you here today? _____

Have you ever been to a Chiropractor before? Y / N

When was your last visit? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

Musculoskeletal Complaints

Area of Concern	Right/Left Both sides	Severity 1=Mild 10=Unbearable	How long have you had this?	Did this start with an injury?	Constant or comes and goes?
Headaches					
Migraines					
Neck					
Upper Back					
Mid Back					
Low Back					
Shoulders					
Hips					
Sciatica					
Knees					
TMJ					

Other Notes:

How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)?_____

_____

Did you know: Torque Release Technique is the most researched chiropractic technique

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Initials: _____ **Date:** _____

What is your main complaint:_____

1. How would you describe the pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness
☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

2. Does the pain travel anywhere else? ☐ Yes ☐ No

Describe:_____

3. How often is this present?

☐ Constant (81 – 100%) ☐ Frequent (51 – 80%) ☐ Occasional (26 – 50%) ☐ Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse or stayed the same? _____

5. What makes your complaint worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Exercise (Moving) ☐ Lying Down ☐ Other

If other, please explain: _____

6. Have you seen anyone else for this health concern? (Medical Doctor, Chiropractor, etc.) If so, who? _____

_____

7. Please list all medications you are taking AND for what:

_____

_____

_____

8. Please list any broken bones, surgeries or hospitalizations you have had and when:

_____

_____

9. Please list any auto accidents or injuries you have been involved in:

_____

_____

Did you know: the head weighs 10-14lbs and rests on a 2oz bone called the atlas vertebra

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Initials: _____ Date: _____

10. Please select any of the conditions below that you (or your family) have or have had in the past with a **C if current issue or a P if past issue:**

	Yourself	Spouse	Children	Mother	Father
Acid Reflux					
Allergies					
Anxiety					
Arthritis					
Asthma					
Cancer					
Bladder Dysfunction					
Cardiac Condition					
Disc Problems					
Dizziness					
Ear Infections					
Epilepsy					
Fainting					
Fatigue					
Fertility					
Fibromyalgia					
High Blood Pressure					
Impotence					
Insomnia					
Irritable Bowel					
Kidney Condition					
Liver Disease					
Lupus					
Menstrual Irregularity					
Nausea					
Nervousness					
Numbness					
Sinus					
Stiffness					
Stomach Condition					
Thyroid Condition					
Ulcers					
Vertigo					

Did you know: there are 24 movable bones in the spine

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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 used 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 subluxations. Our chiropractic method of correction is by specific adjustments to 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 subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

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.

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 _____

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 (HIPAA). 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 physician's 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 used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature _____ Date _____

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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 THE X-RAYS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF LEGACY FAMILY CHIROPRACTIC LLC. DO 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

PRINTED NAME _____ DATE _____

SIGNATURE _____ YOUR AGE _____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT LEGACY FAMILY CHIROPRACTIC LLC.

SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE

Did you know: the first chiropractic adjustment occurred in 1895

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Initials: _____ Date: _____

RECORDS RELEASE AUTHORIZATION FORM

According to The Health Insurance Portability and Accountability Act (HIPAA), Legacy Family Chiropractic LLC. is required by law to maintain confidentiality in regards to any private health information regarding you or your child's care unless given specific permission to do otherwise. If you would like us to be able to share you or your child's private health information with a spouse, loved one, or any other person, please fill out the form below.

I, _____ (print name) authorize Legacy Family Chiropractic LLC. to release confidential information regarding diagnostic assessments, x-rays, medical records, findings, billing information, and/or recommendations for _____(patient name or self) to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that if any of the information above changes, it is my responsibility to inform Legacy Family Chiropractic LLC. and fill out an updated records release form.

Patient Signature: _____ Date: _____

Legacy Family Representative: _____ Date: _____

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QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each 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

What percentage of your awake hours is your pain its best? _____%

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

What percentage of your awake hours is your pain its worst? _____%

Name: _____ Date: _____

Score: Q1 _____+Q2_____+Q3_____+Q4_____=_____/3x10=_____ (Low Intensity = <50; High Intensity = >50)

Did you know: the brain and spinal cord are the only organs in the body completely encased in bone