# ADULT MEMBER HEALTH RECORD

## ABOUT YOU

| | |
|---|---|
| NAME: | |
| ADDRESS: | |
| CITY: | STATE/ZIP CODE: |
| HOME PHONE: | CELL PHONE: |
| EMAIL ADDRESS: | |
| DATE OF BIRTH: | AGE: |
| SOCIAL SECURITY NUMBER: | GENDER: |
| MARITAL STATUS: | NUMBER OF CHILDREN: |
| EMPLOYER NAME: | |
| EMPLOYER ADDRESS: | |
| EMPLOYER CITY: | EMPLOYER STATE/ZIP CODE: |
| WORK PHONE: | POSITION TITLE: |
| PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD | |

## ABOUT YOUR SPOUSE

| | |
|---|---|
| SPOUSE NAME: | |
| SPOUSE EMPLOYER: | |
| EMPLOYER ADDRESS: | |
| EMPLOYER CITY: | EMPLOYER STATE/ZIP CODE: |
| POSITION TITLE: | |

## HEALTH HABITS

| | | | |
|---|---|---|---|
| DO YOU SMOKE? | ❑ YES | ❑ NO | If yes, how much per day_____ |
| DO YOU DRINK ALCOHOL? | ❑ YES | ❑ NO | If yes, how much per week_____ |
| DO YOU DRINK COFFEE, TEA, OR SODA | | | If yes, how much per day_____ |
| DO YOU EXERCISE REGULARLY? | ❑ YES | ❑ NO | |
| DO YOU WEAR: ❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS | | | |

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):
❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ JOB ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY
❑ CHRONIC DISCOMFORT ❑ OTHER

PLEASE EXPLAIN:

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER?
❑ YES ❑ NO

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE? ❑ YES ❑ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

**Bender Chiropractic Healthy & Vitality Center**
33580 Harper Ave.
Clinton Township, MI 48035

## 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 |

## 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 symptom.
- ❑ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ❑ ***I want the Doctor to select the appropriate type of care***

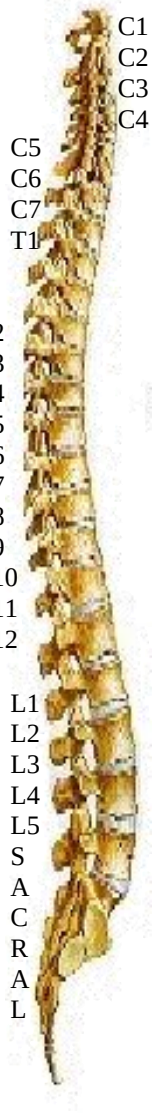
## MEDICATIONS YOU TAKE

| | |
|---|---|
| ❑ CHOLESTEROL MEDICATIONS | ❑ BLOOD PRESSURE MEDICINE |
| ❑ STIMULANTS | ❑ BLOOD THINNERS |
| ❑ TRANQUILIZERS | ❑ PAIN KILLERS (INCLUDING ASPIRIN) |
| ❑ MUSCLE RELAXERS | ❑ OTHER: |
| ❑ INSULIN | ❑ OTHER: |
| ❑ VITAMINS & SUPPLEMENTS: | |

## YOUR CONCERNS

***INSTRUCTIONS:*** *Please* ***circle*** *the health concerns or conditions you may be experiencing now or have in the past. Each area of concern relates to an area of the spine and nerve function.*

*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*

*Constipation*
*Colitis*
*Diarrhea*
*Gas Pain*
*Irritable Bowel*
*Bladder Problems*
*Menstrual Problems*
*Low Back Pain*
*Pain or Numbness in Legs*
*Reproductive Problems*

OTHER:

_____
_____
_____
_____
_____
_____
_____
_____

## HEALTH CONDITIONS

**INSTRUCTIONS:** *Please check each of the diseases or conditions that you now have or have 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.*

| | | | | |
|---|---|---|---|---|
| ❑ SEVERE OR FREQUENT HEADACHES | ❑ THYROID PROBLEMS | ❑ PAIN IN ARMS/ LEGS/HANDS | ❑ NUMBNESS | **FOR WOMEN ONLY:** |
| ❑ HEART SURGERY/ PACEMAKER | ❑ SINUS PROBLEMS | ❑ LOW BLOOD PRESSURE | ❑ ALLERGIES | ARE YOU PREGNANT? ❑ YES ❑ NO |
| ❑ LOWER BACK PROBLEMS | ❑ HEPATITIS | ❑ RHEUMATIC FEVER | ❑ DIABETES | IF YES, WHEN IS YOUR DUE DATE? |
| ❑ DIGESTIVE PROBLEMS | ❑ DIFFICULTY BREATHING | ❑ ULCERS/COLITIS | ❑ SURGERIES: | ARE YOU NURSING? ❑ YES ❑ NO |
| ❑ PAIN BETWEEN SHOULDERS | ❑ KIDNEY PROBLEMS | ❑ TUBERCULOSIS | ❑ ASTHMA | ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO |
| ❑ CONGENITAL HEART DEFECT | ❑ HIGH BLOOD PRESSURE | ❑ ARTHRITIS | ❑ LOSS OF SLEEP | *DO YOU:* EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO |
| ❑ FREQUENT NECK PAIN | ❑ CHEMOTHERAPY | ❑ SHINGLES | ❑ DIZZINESS | HAVE IRREGULAR CYCLES? ❑ YES ❑ NO<br>HAVE BREAST IMPLANTS? ❑ YES ❑ NO |

**Section 8: Notice of Privacy Practices Acknowledgement**
**Initial Uses Authorization Form**
**Bender Chiropractic Health and Vitality Center**

Effective: 4-15-2003

By signing this form, you acknowledge that you were given access to a copy of the Notice of Privacy Practices of Bender Chiropractic Health and Vitality Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Dr. William L. Bender

Bender Chiropractic Health and Vitality Center also uses protected health information for the following reasons: (you may opt out of this authorization). Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (Please initial to give us authorization)

If you have any questions regarding this notice or our health information privacy policies, please contact:
Dr. William L. Bender

You can reach the Privacy Official at: Bender Chiropractic Health and Vitality Center, 33580 Harper Avenue, Clinton Township, MI, 1-586-296-6242
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address:_____ (you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature:_____

==========

Staff complete only if NO signature is obtained, if it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

- ☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- ☐ Other:

_____

Staff Signature:_____Date: _____

**PATIENT CASE HISTORY**
***FOR OFFICE USE ONLY***

CHIEF CONCERNS:

| When did this happen? | How did this happen? | Have you had this condition before? |
|---|---|---|
| Is your condition getting:<br><br>Better / Worse / Staying the same | Does the pain travel or radiate anywhere? | Severity of pain:<br>0 (no pain) – 10 (call an ambulance)<br>Initial Onset:<br>Current:<br>Average: |
| When do you have your pain? Is it worse during certain times of day? | Does this condition interfere with any activities of daily living? (sleeping, bathing, dressing, taking care of yourself) | Aggravating Factors |
| What makes it feel better | Is there anything you can't or are limited doing because of this condition? | What have you done for this condition so far? |

Any of the following? (circle positive)

| NEUROLOGICAL | INFECTION | NEOPLASTIC |
|---|---|---|
| Numbness / Tingling / Weakness | Fever / Chills / Fatigue | Night Pain |
| Coldness / Color Change | Sweating | Night Sweats |
| Headaches / Dizziness | Anorexia | Unexpected Weight Loss |
| Pain upon Coughing, Sneezing, or Straining | | Deep Boring Bone Pain |
| Loss of Bowel or Bladder Control | | |
| **METABOLIC** | **GENITOURINARY** | **CARDIAC** |
| Increased: Thirst / Hunger / Urination | Increased Frequency of Urination | Shortness of Breath / Chest Pain |
| Temperature Intolerance | Hesitation before Urination | Rapid Heart Rate / Rapid Heart Rate |
| Unexpected Weight Changes | Abnormal Urine Color Changes | Swollen Ankles |
| **PULMONARY** | **GASTROINTESTINAL** | |
| Trouble Breathing | Nausea / Vomiting | |
| Coughing | Diarrhea / Constipation | |

Prior Injuries/Illnesses, Hospitalizations/ER, Surgeries, Traumas, Any Other Health Conditions

FAMILY HEALTH HISTORY:

OTHER:

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33580 Harper Ave.
Clinton Township, MI 48035