PATIENT HEALTH HISTORY

☐ P1 ☐ P2 ☐ MP24 ☐ MP12 ☐

Fam

Name: ______________________________ Birth Date: ___/___/___ Age: ______

Address: ______________________________ Sex: ☐Male ☐Female

City: ________________ State: ____ Zip: ________ Home Phone: ______________________

Social Security #: ______________________ Cell Phone: ______________________

Drivers License # and state: ________________ E-Mail Address: ______________________

Employer: ______________________________ Business Phone: ______________________

Occupation: ______________________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Significant others name: ____________________ Significant others Employer: ________________

Significant others Occupation: ________________ Number & ages of Children: ________________

Referred to this office by? ____________________ ______________________________

Name of emergency contact: ____________________ Phone: ___________ Relationship: ___________

INSURANCE

Do you have health insurance? ☐ Yes ☐ No (for our records we will take a copy of your insurance card)

Who is the primary card holder? ____________________ What is their date of birth? ____________

Is patient covered by additional insurance? ☐ Yes ☐ No Please list: ______________________________

INJURY INFORMATION

Is this injury work related? ☐ Yes ☐ No Is this injury auto related? ☐ Yes ☐ No Date of Injury: ___________

GOALS FOR CARE

People see Chiropractors for a variety of different reasons. Some go for relief of pain, some to correct the cause and others for prevention. Your Doctor will weigh your needs and desires when recommending your health 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, relieving, stabilizing the cause of the problem.

☐ Prevention – Maintaining the body to the highest degree of health possible.

☐ I want the Doctor to select the type of care appropriate for my conditions.

List any other Doctors you have consulted for this condition:

1. ______________________________ 2. ______________________________

Primary Physician: ______________________________ If needed, do we have your permission to send information regarding your care to your primary physician? ☐ Yes ☐ No

Have you received Chiropractic care before: ☐ Yes ☐ No When: ______________________________

Patient Signature: ______________________________ **Date:** ________________

MAIN
Health Solutions

Name: ______________________________ **Date:** ____________ **Chief Complaint**

#1 What is the reason for your consultation? Please list ANY & ALL of your health problems in order of importance.

____
____
____

#2 Since when have you had your main problem?___________________________________

#3 How did your main problem begin:
☐ Gradually ☐ Suddenly ☐ Accident / Trauma ☐ Do not know

#4 Is your problem present: ☐ 100% of the time ☐ 50% of the time ☐ less than 25% of the time
☐ 75% of the time ☐ 25% of the time

#5 Is your problem getting: ☐ Better ☐ Worse ☐ Staying the same

#6 Is your problem worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

#7 Does your problem affect your: ☐ Working ☐ Sleeping ☐ Recreation ☐ Family ☐ Daily routine

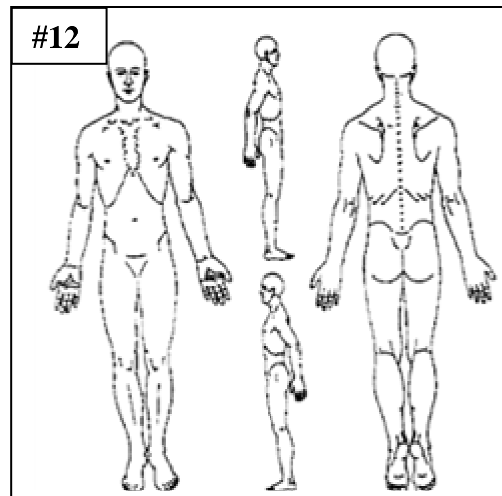
#8 Have you seen another health professional for your problem?
☐ No ☐ Chiropractor ☐ Medical ☐ Physical Therapy
☐ Other; ____

#9 Have you had your main problem before? ☐ Yes ☐ No

#10 Indicate the severity of your main problem when at its worst.
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

#11 Indicate your level of commitment to correcting your problem?
(Not Committed) 0 1 2 3 4 5 6 7 8 9 10 (Very Committed)

#12 Indicate on the body diagram ALL areas with ANY problems.
Please mark EVERYTHING no matter how small and even
if it is not the reason for your consultation.



PREGNANCY RELEASE:

To the best of my knowledge I am not pregnant. I understand that x-rays can be harmful to an unborn child.

Date of last menstrual cycle: ___________ **Patient Signature:**____________________ **Date:**_________

CONSENT TO EVALUATE AND TREAT MINOR CHILD:

I being the parent or legal guardian of the aforementioned minor child (patient) give my permission to their evaluation, x-ray and Chiropractic care.

Patient (Guardian) Signature: _________________________________ **Date:** __________

Patient Signature: _______________________________________ **Date:** __________________

MAIN
Health Solutions

Name: ________________________________ **Date:** ____________ **History / Symptoms**

#1 Father's Age ____. If deceased, what was the cause: ________________________________

#2 Mother's Age ____. If deceased, what was the cause: ________________________________

#3 Do you have brothers or sisters? ☐ Yes ☐ No

#4 Do members of your family have: ☐ Heart Problems ☐ Diabetes ☐ Other: _________________
☐ Cancer ☐ Arthritis _________________

#5 Are you taking any medications? ☐ No ☐ Hormones
☐ Anti-inflammatory ☐ High Blood Pressure
☐ Pain Killers ☐ Diabetes
☐ Muscle Relaxants ☐ Thyroid
☐ Non-prescribed ☐ Birth Control

#6 What is your work position: ☐ Standing ☐ Sitting ☐ Moving

#7 Do you usually sleep on your: ☐ Back ☐ Side ☐ Stomach

#8 How many hours do you sleep at night? ☐ 4hrs or less ☐ 5-6 hrs ☐ 7-8 hrs
☐ 8-10 hrs ☐ 10-11 hrs ☐ 12 hrs or more

#9 Do you consume and if yes, how many: Tobacco / Cigarettes ☐ Yes ☐ No _________________
Alcohol ☐ Yes ☐ No _________________
Coffee / Tea ☐ Yes ☐ No _________________
Vitamins / Supplements ☐ Yes ☐ No _________________

#10 Do you exercise? ☐ Yes ☐ No

#11 Have you had or do you have any of the following problems?

☐ Allergies ☐ High Blood Pressure ☐ Hearing Problems ☐ Epilepsy ☐ Shaking
☐ Anxiety ☐ Hypoglycemia ☐ Hormonal Problems ☐ Skin eruption ☐ Foot problems
☐ Arthritis ☐ Urinary problems ☐ Psychological problems ☐ Dizziness ☐ Heart problems
☐ Abdominal Gas ☐ Insomnia ☐ Kidney Problems ☐ Loss of consciousness
☐ Low Blood Pressure ☐ Irritability ☐ Varicose vein problems ☐ Circulation problem
☐ Constipation ☐ Hereditary disease ☐ Nose bleeds ☐ Respiratory problem ☐ Cold extremity
☐ Convulsions ☐ Back pain ☐ Blood in the stool ☐ Fatigue ☐ Eye problem
☐ Itching ☐ Headaches ☐ Blood in the urine ☐ Respiratory problem ☐ Fractures
☐ Depression ☐ Meningitis ☐ Sinusitis ☐ Sexual problems ☐ Shivers
☐ Diabetes ☐ Edema (swelling) ☐ Frequent urination ☐Operations / Surgery
☐Diarrhea ☐Urinate at night ☐ Easily bruised ☐ Weight loss / gain ☐ Prostate problems ☐
Cancer
☐ Numbness ☐ Kidney stones

Add details or other items here: ____
____
____

Patient Signature: ________________________________ **Date:**_________________

MAIN
Health Solutions

Patient Name____ **Date**________

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? ______________________________________

What speed was the collision? ____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe __________________________________

When was your most recent strain / stress at work? __________________________________

Please describe the manner of the injury _____________________________________

Was treatment received? Please describe ___________________________________

Does your job require you remain in long term stressful postures?___________________

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____________________________________

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____________________________________

Trauma as a child! i.e. fall on your head, impact to your head, concussion,
fall onto your back or tailbone, biking accident_______________________________________

Work around the house – lifting, bending, woke up with stiff neck, "back went out"

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values?_____________

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N) _______

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:

____
____
____

MAIN
Health Solutions

Patient Name____ **Date**___________

INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular ___Hours ___Days/Wk Weight Training ___Hours ___Days/Wk

Low Impact (Yoga, etc.) ___Hours ___Days/Wk

What is your target weight? _____________What is your current weight? ___________

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10)*** ________

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? _____ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night (Y/N)

Do you average less than 7 hours of sleep per night (Y/N)

Do you ever take pills to go to sleep or relax (Y/N)

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

OFFICE POLICY

It is my responsibility to inform this office of any changes in my health status, insurance or my contact information.

– **INSURANCE:** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. All professional services rendered are charged directly to the patient (me) and are my responsibility. We require that your examination day and 1rst adjustment charges be paid in full when services are rendered and until insurance coverage has been verified. If your yearly deductible has not been met, if any services are denied or non covered, if your coverage becomes inactive or you have met the maximum benefit fees for services will be your responsibility. In the event that your insurance check is mailed to you we expect you to present it to this office if there are charges owed.

– **CASH:** Fees are paid at the time of service, unless special arrangements have been made in advance. If special arrangements are made and you become inactive by discontinuing your care, your entire unpaid balance will be due immediately and may be charged in full to the credit or debit card on file if other arrangements are not made. This applies to all plan types except Auto Injury and Work Injury claims.

– **WORKMAN'S COMPENSATION:** Report your accident to your employer, bring in the necessary insurance information, and complete and sign the appropriate forms for billing by the second visit. We will bill your insurance directly. In the event you receive the insurance check, we expect you will present the check to our office.

– **AUTO INJURY:** We require you provide us with the accident report, your car insurance, health insurance, liable parties insurance, and attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. All charges are ultimately the responsibility of the patient or guardian in the event insurance doesn't pay. If you receive the insurance check, we expect you will present the check to our office. By signing this form you are authorizing our office to bill all possible insurance available including your auto insurance, the third party insurance and your health insurance. By signing you are authorizing the insurance companies involved to pay directly to us to cover any and all charges incurred for your care in our office for this injury.

Any treatment remaining unpaid after (60) days will bear interest at the highest legal annual rate of interest allowed in Idaho until paid. If the office has to hire an attorney, collection agency or use outside means of collecting past due bills, you must reimburse the office for any attorney fees, court costs or collections spent in collecting the bill.

AUTHORIZATION TO RELEASE INFORMATION

I authorize you to release any information deemed appropriate to any insurance company, attorney or adjuster in order to process my claims for reimbursement, and I release you of any consequence thereof. We may disclose your personal health information (PHI) to family members of close friends whom accompany you if we determine it's in your best interest so we may provide you with the best care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care. You have the right to request a restriction in how we use your or disclose your PHI.

PRIVACY PRACTICES

I have received or reviewed the privacy practice notice (4 pages) for Main Health Solutions, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Initial Intake Paperwork) on my first visit, whenever that may have occurred. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

OPEN ENVIRONMENT

We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request a special appointment in one of our private rooms. A doctor or trained staff member will speak with you about your condition, concern or other matters.

TERMS OF ACCEPTANCE

We DO NOT diagnose conditions or diseases, other than vertebral subluxations.
We offer NO treatment of conditions or disease, other than vertebral subluxations.
We promise NO cure from any condition or disease.

OUR GOAL

To locate, analyze and correct spinal interference to the nervous system. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION is a detriment to life and health. Correction of the subluxation through specific chiropractic adjustment, allows the body to function at its optimal level. This allows innate healing power of the body to work at a maximum efficiency to restore, maintain and promote natural healing.

I, ________________________________ have read the above statement and completely understand it. I do undertake chiropractic health care on this basis. (Print Name)

SIGNATURE ________________________________ DATE ___________________ STAFF ___________________

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Main Health Solutions have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ ____/____/____ *Witness Initials*

Patient or Authorized person's Signature Date

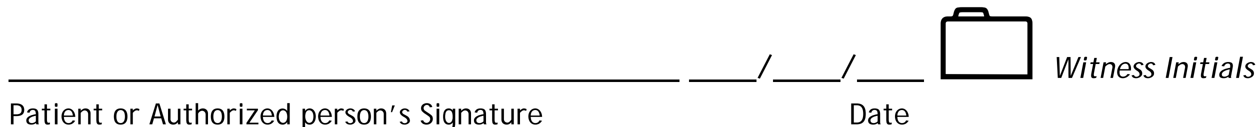
REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.



____ ____/____/____ *Witness Initials*

Patient or Authorized person's Signature Date

JDD,DC 5/2011