****

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_ Stomach Issues \_\_\_ 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 had any previous surgeries? Yes No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had or currently have cancer? Yes No

**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.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**