

RESTORATION CHIROPRACTIC CO.

Welcome to our office! We are sure that you will be provided the most appropriate and professional chiropractic care possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with today's examination procedures, which will determine how we can help you, we want you to understand what we do and why we are going to do it.

The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they are both working towards the same goals.

Most importantly, you must understand that chiropractic is not a substitute for medical treatment of any kind, in any way, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness, and disease care, and it is necessary in emergency situations. Chiropractic recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is true healthcare, focusing on the optimum function of the individual, and it's what we do in our office.

The purpose of chiropractic is to restore and maintain the integrity of the spine, spinal cord, and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interferences (pinched nerves) and cause dysfunction to the tissues and organs that these nerves supply.

With appropriate chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nervous system is the foundation to good health.

The information we get from you is important. We use your health history, x-rays, computerized muscle assessment, and palpatory examination to locate subluxations. For this reason, please fill out our history forms completely and to the best of your ability. It will save us from doing unnecessary tests and give us the most accurate information.

Please feel free to ask any questions at any time to the staff or doctors in our office and again, welcome. We look forward to a healthy relationship with you and your family.

Sincerely,

Dr. Ian McCann & Restoration Chiropractic Co. Staff

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
MARITAL STATUS:	# OF CHILDREN:
EMPLOYER'S NAME:	
EMPLOYER'S ADDRESS:	
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S DATE OF BIRTH:	

ABOUT YOUR SPOUSE

SPOUSE'S NAME:	
ADDRESS:	
CITY:	ZIP CODE:
HOME PHONE:	CELL PHONE:
SPOUSE'S EMPLOYER'S NAME:	
EMPLOYER'S ADDRESS:	ZIP CODE:
EMPLOYER'S CITY/STATE:	POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	HOW OFTEN?	_____
DO YOU DRINK ALCOHOL?	<input type="checkbox"/> YES <input type="checkbox"/> NO	HOW OFTEN?	_____
DO YOU DRINK COFFEE, TEA, OR SODA?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
DO YOU EXERCISE REGULARLY?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, HOW OFTEN?	_____		
IF NO, IS THAT SOMETHING YOU'D LIKE TO IMPROVE?	_____		
DO YOU WEAR:			
<input type="checkbox"/> ARCH SUPPORTS			
<input type="checkbox"/> HEAL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INSOLES			

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
DID YOU SEE OR HEAR OF OUR OFFICE BECAUSE OF (CHECK ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> MAILING <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> OTHER _____
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR OF CHIROPRACTIC'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?
HAS ANY CHILD 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: <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> HOME INJURY <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> OTHER _____
PLEASE EXPLAIN:
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH : <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME(S) OF DOCTOR(S):
TYPES OF TREATMENTS:
RESULTS:

ARE YOU AWARE THAT:

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

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

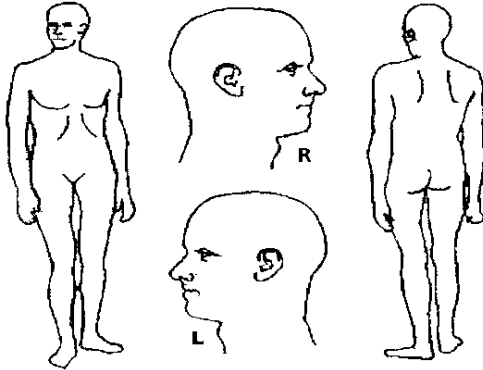
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ☐ YES ☐ NO

IF CHIROPRACTIC CARE STARTS AT BIRTH, ONE CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? ☐ YES ☐ NO

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL	<input type="checkbox"/> BLOOD PRESSURE	<input type="checkbox"/> STIMULANTS
<input type="checkbox"/> BLOOD THINNERS	<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> ASPIRIN/ETC.	<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> OTHER (list below)	<input type="checkbox"/> OTHER (list below)	<input type="checkbox"/> OTHER (list below)
<input type="checkbox"/> VITAMINS & SUPPLEMENTS:		

MARK AREAS OF PAIN WITH AN "X"



YOUR CONCERNS

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

SORE THROAT
STIFF NECK
RADIATING ARM PAIN
HAND/FINGER NUMBNESS
ASTHMA
ALLERGIES
HIGH BLOOD PRESSURE
HEART CONDITIONS

C1 HEADACHES
C2 MIGRAINES
C3 DIZZINESS
C4 SINUS PROBLEMS
ALLERGIES
FATIGUE
HEAD COLDS
C5 VISION PROBLEMS
C6 DIFFICULTY CONCENTRATING
C7 HEARING PROBLEMS
T1

T2 MIDDLE BACK PAIN
T3 CONGESTION
T4 DIFFICULTY BREATHING
T5 BRONCHITIS
T6 PNEUMONIA
T7 GALLBLADDER CONDITIONS
T8 STOMACH PROBLEMS
T9 ULCERS
GASTRITIS
KIDNEY PROBLEMS

CONSTIPATION
COLITIS
DIARRHEA
GAS PAIN
IRRITABLE BOWEL
BLADDER PROBLEMS
MENSTRUAL PROBLEMS
LOW BACK PAIN
PAIN OR NUMBNESS IN LEGS
REPRODUCTIVE ISSUES

L1
L2
L3
L4
L5
S
A
C
R
A
L
OTHER: _____

HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you have now 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 possibility of being accepted for care.

<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS	<input type="checkbox"/> NUMBNESS	FOR WOMEN ONLY:
<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	
				ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
				IF YES, WHEN IS YOUR DUE DATE? _____
				ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO

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 disclosure for the purposes of treatment, payment, or practice parathion will be made only after obtaining your consent:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your 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.*

I have read and understand 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 or disclosed.

PATIENT'S NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE:

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient 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 of the body. This can cause pain or alteration of nerve function and interference of the transmission of 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 subluxations. 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 question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:

DATE:

WITNESS' SIGNATURE:

DATE:

PAYMENT AGREEMENT/USE OF INSURANCE AUTHORIZATION

I hereby authorize the Doctor(s) of Restoration Chiropractic Co., PA to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by 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. Restoration Chiropractic Co., PA will not be held responsible for any preexisting 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 by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Restoration Chiropractic Co., PA 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 Restoration Chiropractic Co., PA 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 Restoration Chiropractic Co., PA will be credited to my account upon receipt.

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

- ☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ WORKERS COMP ☐ AUTO INSURANCE
- ☐ MEDICARE ☐ HEALTH INSURANCE

Signature:	Date:
Guardian or Spouse Authorizing Care's Signature:	Date:

RESTORATION CHIROPRACTIC — CO. —

Date: _____

I give permission to Restoration Chiropractic Co. and the doctors who own the facility, to use my photographs, videos, and any handwritten or emailed testimonials from me for advertising purposes both internal and external. This would include but is not limited to: newsletters, print ads, websites, social media, in-office use, and any other promotional items for the office.

Should I request to have my photos, videos, or written testimonials removed, I will inform the doctors in writing.

Name (printed): _____

Name (signature): _____