Patient Health History for Well-Adjusted Chiropractic

Today's Date _____/_______/_________ **Referred by:**______________________________

First Name__________________ **Last Name** _________________**Middle Name** _____________

Address ____

City______________________________ **State**________ **Zip Code**______________

Primary Phone ______________________________(best way to contact you)

Home email ____

(By providing my email address, I authorize my doctor to contact me via the email address (es) provided.)

Signature of Patient _____________________________ **Social Security** ______-____-________

Date of Birth _____/_______/_____ **Age** ____________ **Gender** *(check one)* ❑ Male ❑ Female

Preferred Title: *(check one)*❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

Marital Status *(check one)* ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Divorced

Employment Status *(check one)*

❑ Employed ❑ Student ❑ Other ❑ Retired ❑ Self Employed

If employed, what is your occupation:______________________

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other__________	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Vietnamese	❑ Italian	❑ Korean	❑Russian	❑ Portuguese	❑ Japanese

Height:________ **Weight:** _______ **BP:** _____/_______(If known)

****Please assure you have given the front desk your most up to date insurance card and driver's license. Please be aware that payment is due BEFORE treatment. Thank you for your understanding!**

List any Allergies:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen
☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat
☐ Medications (ALLERGIES)________________________________ ☐ Other: __________________________

List any Surgeries:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: __________

List ALL Past Medical History Conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression
☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain
☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure
☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain
☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's
☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain
☐ Stroke/Heart Attack ☐ Other:_________________________

List your Family History:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition
☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio
☐ Prostate Problems ☐ Stroke/Heart Attack ☐ Other: ____

Have you had any auto or other accidents? ☐ No ☐Yes

Describe: ____

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest *Very Interested*

Do you drink alcohol? ☐ **No** ☐**Yes - how many per day?** __________

Do you drink caffeine? ☐ **No** ☐**Yes - how many per day?** ______________

Do you exercise? ☐ **No** ☐**Yes (what forms and how often):** ____

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****List current medications, supplements, and/or herbs including frequency and dosage(if known) below.**

(If there are no current medications leave blank.)

Are you pregnant? Yes No Due Date: ______________

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe:

____

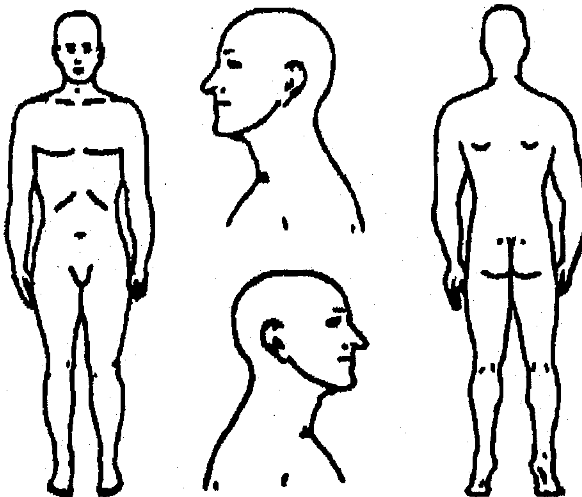
Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ____________________________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- ☐ **Become pain free**
- ☐ **Explanation of my condition**
- ☐ **Learn how to care for my condition**
- ☐ **Reduce symptoms**
- ☐ **Resume normal activity level**

What is your major complaint? ______________________________ **Date problem began?** ____________________

How did this problem begin (falling, lifting, etc.)? ____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

**Please assure you have given the front desk your most up to date insurance card and driver's license.
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How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ______________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? ______________________________

What makes your pain better (ice, heat, massage, etc)? ______________________________

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Well-Adjusted, Inc
312 8th Avenue, West
Hendersonville, NC 28791

828-698-7888

ACKNOWLEDGEMENT FORM

- I have reviewed the posted Notice of Privacy Practices located in the office lobby below the front office window and agree to what is stated on it.

Name:______________________________

Birthdate:____________________________

Signature:____________________________

Date Signed:___________________________

INFORMED CONSENT TO CHIROPRACTIC CARE

****Please assure you have given the front desk your most up to date insurance card and driver's license. Please be aware that payment is due BEFORE treatment. Thank you for your understanding!**

Well Adjusted Inc.
Dr. Jennifer S. Hensley
312 8th Avenue, West
Hendersonville, NC 28791
828-698-7888

Office Policies/ Informed Consent to Chiropractic Care:

We welcome you as a new patient to our office. We appreciate the confidence you have shown in us by consulting this office concerning your present health condition(s). We invite you to discuss with us any questions regarding our services.

Our policy requires payment in full rendered at time of visit, unless other arrangements have been made with our staff. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other fees, and expenses incurred in collecting your account.

New Patient and Re-Exam Policy. New Patients are defined by any person who has not received service by the Doctor in over 3 years. Those patients will be treated as a New Patient,and subject to the New Patient paperwork and fees.

Existing patients and Re-exams. If an existing patient has not been in for treatment in over 1 year- they will be required to be responsible for insurance update, updated patient records, and Re-exam fee.

Please be on time for your appointment. Our treatment methods require adequate time; coming late for appointments is not acceptable to the office and will not serve your health interests. If an emergency should arise, please phone the office and ask if you should come in for the visit or reschedule your appointment.

Our office requires 24 hours notice on all cancellations. In the case of any late cancellations or missed appointments there will be a $25.00 charge. Patients that repeatedly miss appointments will be charged for the full amount of the scheduled treatment.

Our office has an answering machine in order for us to serve you efficiently. If the office is closed, please leave your name, telephone number (including area code), and your message on the machine. We will return your call as soon as possible.

Please read and sign below:
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above. I have had the opportunity to discuss with the doctor and/ or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments. Alternative types of care have been reviewed. Though chiropractic adjustments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to adjustments. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains and bruises. I understand that chiropractic is not an exact science and that therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic adjustment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

I acknowledge that I have read the above office policies and informed consent:

Signature of Patient____Date___________________

*Signature of Parent/Guardian________________________________Date___________________

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