ADULT HEALTH HISTORY

Name_____ DOB_____ Age:___ □ Male □ Female

Address_____City_____State_____Zip_____

Home Phone _____Work Phone_____Cell Phone _____

□ Single □ Married □ Divorced □ Widowed # of Children & Ages _____

SS# _____-_____-_____ E-mail_____

Employer _____Occupation (describe) _____

Spouse's Name _____ Spouse's Occupation_____

Whom may we thank for referring you?_____ □ Phone Book □ Website □ Sign □ Other_____

__ Check here if you have no complaints and are here for a wellness program (skip current complaint)

Current Complaint: *(circle, highlight or write where applicable)*

Please indicate in order of importance ALL complaints you are experiencing and briefly describe.

1st Complaint_____

_____

a. Been a problem for: (please specify #) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM In Bed It Varies It's getting: Better Worse No Change

f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

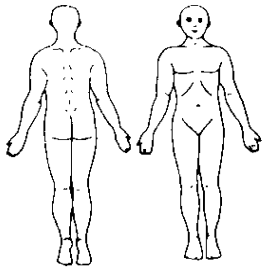
g. What makes it better?_____

h. What makes it worse?_____

i. Have you seen anyone for this? Yes No Who?_____

j. How does it interfere with your life (sleep, work, play, driving, lifting, etc.)_____

Mark areas below



2nd Complaint_____

_____

a. Been a problem for: (please specify #) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM In Bed It Varies It's getting: Better Worse No Change

f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

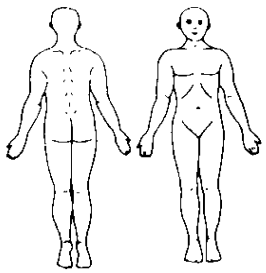
g. What makes it better?_____

h. What makes it worse?_____

i. Have you seen anyone for this? Yes No Who?_____

j. How does it interfere with your life (sleep, work, play, driving lifting, etc.)_____

Mark areas below



3rd Complaint_____

_____

Are ANY of the above complaints related to an auto or work injury? Yes No_____

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Wellness Profile: Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve. *(Circle as many goals as you wish)*

More Energy	Better Sleep	Freedom from Pain
Easier Breathing	Improved Posture	Improved Nutrition & Diet
Improved Coordination	Eliminate Medications	Improved Overall Health
Better Sports Performance	Stress Reduction	Better Concentration
Stronger Immune System	Other_____	

Spinal Health: *(circle, highlight or write where applicable)*

1) Have you ever visited a doctor of chiropractic before? Yes No Who?_____
   When was your last visit?_____ Reason for ending care?_____
2) Have you ever had spinal x-rays taken? Yes No When?_____ Were you standing? Yes No
3) Do you have: Scoliosis Spinal Arthritis Inherited Spinal Problem_____
4) Spinal misalignments cause decay and degeneration which results in grinding or cracking.
   Do you ever hear noises when you move your head or neck? Yes No
5) Spinal misalignments can make you feel the need to twist, stretch or crack your neck or spine.
   Do you ever feel the need to twist, stretch or crack your neck or spine? Yes No
6) Poor posture leads to poor health and often indicates spinal problems. Please rate your posture.
   Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent
7) Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
   Low - 1 2 3 4 5 6 7 8 9 10 - High
8) Have you ever had spinal surgery? Yes No If yes, when & where? _____

Health History: *(circle, highlight or write where applicable any **past or present** health challenges)*

ADD / ADHD	Allergies	Arthritis	Asthma	Cancer
Constipation	Diarrhea	Diabetes	Digestive Issues	Epilepsy
Eating Disorder	High Blood Pressure	Herniated Disc	Migraines	Headaches
Learning Disorder	High Cholesterol	Pinched Nerve	Osteoporosis	Stroke
Repeat Infections	Frequent Colds	Fibromyalgia	Sinus Problems	Acid Reflux
Thyroid Problems	Tumor/Growth	Depression	RA	MS
Infertility	Hot Flashes	Menstrual Problems_____		
Sleeping Problems_____		OTHER_____		

Do you exercise: Yes No How often: _____ Type:_____
Do you smoke: Yes No How often: Daily Weekly Occasional
Do you drink caffeine: Yes No How often: Daily Weekly Occasional
Do you drink alcohol: Yes No How often: Daily Weekly Occasional
List any allergies: No known / _____
Vitamins/Herbs/Minerals/etc: None / _____
Current medications: None / _____
Please rate the following as (P) Poor, (G) Good or (E) Excellent:
Diet – P G E Sleep – P G E Mental State – P G E General Health – P G E

Continued on next page...

Injuries/Surgeries: *(Date & Description)*

Auto Accidents: N/A / _____

Recreational Accidents: N/A / _____

Fractures / Dislocations: N/A / _____

Surgeries: N/A / _____

Family History:

Does anyone in your family suffer with any of the following conditions? *(Please circle or highlight Father &/or Mother)*

F M Heart Disease F M Stroke F M Cancer (types):_____

F M High BP F M Thyroid F M Neurological *(Parkinson's, ALS, MS)* other_____

F M Diabetes F M Asthma F M Other_____

Would you like to receive our health and wellness newsletter (1-2 times per month via email)? Yes No
(Topics include: diet, exercise, stress management, women's and children's health, wellness topics, etc.)

Fees & Care Plans:

Initial Exam	$80
X-rays	$70/set (typically 2 sets with initial start up)
Adjustments	$40
Re-Exam	$50

On your second visit, Dr. Sullivan will review the results of your exam and go over your care plan. We will also review your financial responsibilities regarding your care. If you have insurance, please read the section below.

Insurance: We used to be 'in network' with many insurance companies; however, we found being 'out of network' offered most of our patients *better* coverage and *fewer* restrictions. Currently we are 'in network' with BC/BS & Medicare. We are considered 'out of network' for all others. You may call the (800) number on the back of your card to check your coverage; however, we will call to verify your chiropractic benefits and discuss them with you on your second visit when the doctor reviews your care plan.

MEDICARE – Medicare has limited chiropractic coverage; however, they ***DO NOT*** contribute towards the ***initial exam or x-rays*** in a chiropractic office. Your initial visit will most likely include the initial exam ($80) and both sets of x-rays ($140), for a total cost of $220.

MEDICAID – Currently Medicaid DOES NOT offer ANY chiropractic benefits. The fees listed above will be your full financial responsibility if you have Medicaid or any Medicaid type policy.

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care whether or not paid by insurance. If I have insurance, I authorize and assign all insurance benefits payable to me for services rendered if BC Family Chiropractic accepts assignment on my behalf. I authorize use of my signature below on all insurance submissions. Copies of any x-ray reports will be released upon written request, however the original films are the sole legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 years.

The above information is true and accurate to the best of my knowledge.

Patient Name	Patient Signature	Date	Dr. Initials
_____	_____	_____	_____

Informed Consent for Female Patients: By signing below I acknowledge that I understand the hazardous effects of x-rays to an unborn child and that I am not pregnant to the best of my knowledge. The first day of my last menstrual cycle was on _____. I hereby consent to have any diagnostic x-ray exam the doctor deems necessary.

Patient Signature	Date	Dr. Initials
_____	_____	_____

Continued on back...

ACTIVITIES OF DAILY LIVING

In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

		0	1	2	3	4
1)	**Pain Intensity:**	None	Mild	Moderate	Severe	Unbearable
2)	**Frequency of Pain:**	None	25% of the day	50% of the day	75% of the day	Constant
3)	**Lifting:**	No Pain w/ Heavy Weight	Increased Pain w/ Heavy Wt.	Increased Pain w/ Moderate Wt.	Increased Pain w/ Light Wt.	Increased Pain w/ Any Wt.
4)	**Walking:**	No Pain w/ Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain w/ Any Distance
5)	**Standing:**	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain w/ Any Standing
6)	**Travel:** (Driving)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
7)	**Work:**	Do Usual Work + Unlimited Extra	Do Usual Work But No Extra	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
8)	**Sleeping:**	Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Severely Disturbed	Totally Disturbed
9)	**Personal Care:** (Washing, Dressing, etc.)	No Pain	Mild Pain	Moderate Pain	Severe Pain	Unbearable Pain
10)	**Recreation:**	Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activities

Patient Signature:_____ Date:_____ Score:_____