



Adult Health History

General Information

Name: _____ Date: _____

Address: _____
Street City State Zip code

Phone Number: _____ Date of Birth: _____

E-Mail: _____ Age: _____ Gender: Male Female

Occupation: _____ Employer: _____

Previous Chiropractor: _____ Last Visit: _____

Present Medical Doctor: _____

How did you hear about our office? _____

Social History

Circle One: Single Married Divorced Separated Widowed

Number of Children: _____ Spouse's Name (if applicable): _____

Level of Education Completed: _____

How often do you eat a well-balanced diet? Circle one.

Never Rarely Occasionally Usually Regularly

How often do you exercise? Circle one.

Never Rarely Occasionally Usually Regularly

What type of exercise? _____

Do you drink alcohol? Circle one.

Never Rarely Occasionally Frequently Daily

Do you use tobacco products? Circle one.

Never Rarely Occasionally Frequently Daily

Have you ever used recreational/illegal drugs? Yes No

Have you had a substance abuse problem? Yes No

If yes, have you had treatment for this problem? Yes No

Family & Medical History

Are/were your parents or siblings diagnosed with any of the following diseases? Please circle.

Arthritis Depression High Blood Pressure Heart Disease
High Cholesterol Diabetes Chronic Pain Cancer (Type) _____

Other (Please specify): _____

Do you currently or have you ever been diagnosed with any of the diseases mentioned in the previous question? If yes, please list and indicate any others not specified above.

What specific concern(s) brought you into the office today? How long have you been dealing with this/these concerns?

Have you undergone any surgeries or been hospitalized for any reason? (Please indicate year if possible)

Have you ever been in a motor vehicle accident (including 4-wheeler, motorcycle, dirt bike, etc.)?

Are you currently taking any prescription or over the counter medications? (Name, strength, dosage)

Are you currently taking and vitamins/supplements? (Please specify)

Is there any other information you would like us to know?

Signature: _____ Date: _____



Okemos Family Chiropractic

Acknowledgement of Notice of Privacy Practices

I acknowledge that:

I received a copy of the Medical Practice's Notice of Privacy Practices.

I was able to review the Medical Practice's Notice of Privacy Practices at the place where I went for health care services.

The Notice of Privacy Practice was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

I know that I can ask for a copy of the Notice of Privacy Practices to take with me.

I was able to view the Notice of Privacy Practice to take with me.

I was able to view the Notice of Privacy Practices on the first day I received health care services after April 14, 2003.

If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practical after the emergency treatment situation ended.

Patient or Patient Representative

Signature: _____ Date: _____

TO BE COMPLETED BY THE MEDICAL PRACTICE

If an acknowledgement was not obtained, the Medical Practice must document, in the space below, its good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained.



Okemos Family Chiropractic

Financial Policy

It is the goal of this practice to provide you with the finest quality chiropractic care available. We are committed to your care at this office and it is our desire to assist you whenever possible. We don't ever want your finances to keep you from getting the care you deserve.

All patients must understand that we do not promise that an insurance company will reimburse this practice for services rendered and ultimately in the event that an insurance company denies payment, it is the responsibility of you the practice member to pay the charges and seek reimbursement from your insurance company.

All Time of Service, co-payments and deductibles must be paid at the time of service as this office has adopted a ZERO balance policy.

All accounts not paid within 90 days will receive final notification and be turned over to a collection agency for further action.

I, _____, have read the above, understand it full and agree to adhere to these financial policies.

Signature: _____ Date: _____

"Have you ever heard of a spine transplant? Neither have we, so take care of the only one you have!"



Okemos Family Chiropractic

Terms of Acceptance for care:

I have been informed and fully understand that Chiropractic care along with any Nutritional advice is not for the treatment of any disease, symptom, or condition.

I understand that the body is a self-healing organism, that the nervous system is the master controller of the body and that any interference to the function of this system creates malfunction within the body.

I understand that Subluxation(s) and or vertebral misalignments interfere with function of my nervous system and produce poor health expression; therefore may result in malfunction of the organ systems of the body.

I also understand that my care is aimed to reducing and or correcting Subluxation(s) thereby restoring or optimizing my fullest health potential.

I understand that the Nutritional consultations are not to diagnose any disease but rather help facilitate the body towards optimal health and function.

I have been informed that my regular chiropractic adjustments are done in a semi-open adjusting area for the sole purpose of education, and understand that any health concerns which need to be addressed privately can be done in a private consultation room during scheduled consultation hours.

Print name: _____ Date: _____

Signature: _____

Witness: _____