ADULT CONSULTATION HISTORY

Date: _____ File #: _____

Welcome to our practice! Please complete all questions. Thank you.

Name (printed): _____ Preferred Name: _____

Address: _____ City:_____ State:_____ Zip:_____

Phone -Home: _____ Cell: _____ Work: _____

Email: _____ Date of Birth: _____Age: _____

Sex: M F Occupation: _____ Employer: _____

Favorite Hobbies or Interests:_____

Marital Status: M W D S Spouse's Name: _____ # of Children: _____

Children's Names & Ages: _____

_____

Do your children have any health concerns? _____

How did you hear about our office? _____

Purpose for this appointment? _____

Any other concerns? _____

Are you currently taking any drugs? (Please list) _____

Have you had any major surgery or operations? (Please describe) _____

_____

Have you had any major accidents or falls? (Please describe) _____

_____

Any other hospitalizations besides those listed above? (Please describe) _____

_____

Have you had any previous chiropractic care? If so, please list doctor's name and date of last visit if within the last year: _____

Who is your family doctor? _____

Do you have orthotics or wear a heel lift? _____

Mother, Father, Sister, Brother, or Children with same or similar complaints? If yes, who: _____

_____

ADULT CONSULTATION HISTORY

Below is a list of conditions that may seem unrelated to the purpose of you appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- □ Pneumonia
- □ Rheumatic Fever
- □ Polio
- □ Tuberculosis
- □ Whooping Cough
- □ Measles
- □ Mumps
- □ Smallpox
- □ Chicken pox
- □ Diabetes
- □ Cancer
- □ Heart Disease
- □ Thyroid condition
- □ Pleurisy
- □ Arthritis
- □ Epilepsy
- □ Mental Disorders
- □ Eczema

INTAKE:

- □ Coffee
- □ Tea
- □ Alcohol
- □ Cigarettes
- □ Illicit Drugs

CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD IN THE PAST SIX MONTHS:

NERVOUS SYSTEM

- □ Numbness
- □ Paralysis
- □ Dizziness/Fainting
- □ Forgetfulness
- □ Anxiety
- □ Depression
- □ Confusion
- □ Cold/Tingling Extremities
- □ Convulsions
- □ Stress

MUSCULO-SKELETAL

- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Joint Pain/Stiffness
- □ Walking Problems
- □ Difficulty Chewing/Clicking Jaw
- □ General Stiffness

EENT

- □ Vision Problems
- □ Sore Throat
- □ Earaches
- □ Hearing Difficulty
- □ Stuffed Nose

GASTROINTESTINAL

- □ Poor/Excessive Appetite
- □ Excessive Thirst
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Liver Problems
- □ Gall Bladder Problems
- □ Weight Trouble
- □ Abdominal Cramps
- □ Gas/Bloating After Meals
- □ Heartburn
- □ Colitis

URINARY

- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Discolored Urine

C-V-R

- □ Chest Pain
- □ Shortness of Breath
- □ Blood Pressure Problems
- □ Heart Problems/Irregularities
- □ Lung Problems/Congestion
- □ Varicose veins/Ankle swelling
- □ Stroke

GENERAL

- □ Fatigue
- □ Allergies
- □ Loss of Sleep
- □ Fever
- □ Headaches

MALE

- □ Sexual Dysfunction
- □ Prostate Problems

FEMALE

- □ Menstrual Irregularity
- □ Menstrual Cramps
- □ Vaginal Pain/Infection
- □ Breast Pain/Lumps
- □ Sexual Dysfunction
- □ Are you pregnant?
  - □ Yes □ No □ Not Sure

OTHER PROBLEMS:

- □ _____
- □ _____

HIPAA: Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, healthcare, and practice operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
Right to Change: We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices at any time by contacting: Amanda Britten, DC Pathways Family Chiropractic, 3616 N.165th St., Omaha, NE 68116 (402) 889-6127.
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, healthcare, and practice operations. I also acknowledge that I have received a copy of, and agree to, Pathways Family Chiropractic's Notice of Privacy Practices.

_____ _____
Signature Date

TERMS OF ACCEPTANCE

When a practice member seeks chiropractic health care and we accept that person for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each practice member understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: a state of optimal physical, mental, and social well-being, not merely the absence of symptoms or disease.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
Signature Date