

ADULT CHIROPRACTIC HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
PHONE NUMBER:	
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
GENDER:	
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER:	
EMPLOYER NUMBER:	OCCUPATION:

ABOUT YOUR SPOUSE

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:

HEALTH HABITS

DO YOU SMOKE?	YES	NO
DO YOU DRINK ALCOHOL?	YES	NO
DO YOU DRINK COFFEE, TEA, OR SODA?	YES	NO
DO YOU EXERCISE REGULARLY?	YES	NO
DO YOU WEAR:		
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFT <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORT		

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> MUSCLE RELAXORS	<input type="checkbox"/> OTHER

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
WHEN DID THIS CONCERN BEGIN?
HAS THIS CONCERN:
<input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> CAME AND GONE
DOES THIS CONCERN INTERFERE WITH:
<input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONCERN OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN ? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTORS NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT
SURGERIES: _____

SUPPLEMENTS YOU TAKE

<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<input type="checkbox"/> PROBIOTIC
<input type="checkbox"/> MULTIVITAMIN WHICH: _____	<input type="checkbox"/> VITAMIN D3
<input type="checkbox"/> CALCIUM / MAGNESIUM	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> VITAMIN C	<input type="checkbox"/> OTHER _____



FOR WOMEN ONLY

WHEN THE FIRST DAY OF YOUR LAST MENSTRUAL CYCLE?

ARE YOU PREGNANT? YES NO UNSURE

IF YES, WHEN IS YOUR DUE DATE?

ARE YOU NURSING? YES NO

ARE YOU TAKING BIRTH CONTROL? YES NO

HAVE YOU HAD A HYSTERECTOMY OR TUBAL YES NO

DO YOU:

EXPERIENCE PAINFUL PERIODS? YES NO

HAVE IRRREGULAR CYCLES? YES NO

HAVE BREAST IMPLANTS? YES NO

I have completed the pregnancy questionnaire above truthfully and understand that I should not have x-rays if I could be pregnant. I authorize Infinity Wellness Center to perform diagnostic x-rays to help develop a treatment plan. I understand and agree that Infinity Wellness Center is released from all liability and litigation pertaining to myself and my unborn child.

Signature _____ Date: _____

YOUR CONCERNS

Sore Throat

Stiff Neck

Radiating Arm Pain

Hand/Finger Numbness

Asthma

Allergies

High Blood Pressure

Heart Conditions

Headaches

Migraines

Dizziness

Sinus Problems

Allergies

Fatigue

Head Colds

Vision Problems

Difficulty Concentrating

Hearing Problems

Constipation

Colitis

Diarrhea

Gas Pain

Irritable Bowel

Bladder Problems

Low Back Pain

Pain or Numbness in legs

Reproductive Problems

Middle Back Pain

Congestion

Difficulty Breathing

Bronchitis

Pneumonia

Gallbladder Conditions

Stomach Problems

Ulcers

Gastritis

Kidney Problems

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care:** Symptomatic relief of pain or discomfort,
- Corrective care:** Correcting and relieving the cause of the problem as well as the symptoms.
- Comprehensive care:** Bringing whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

Rate your health :

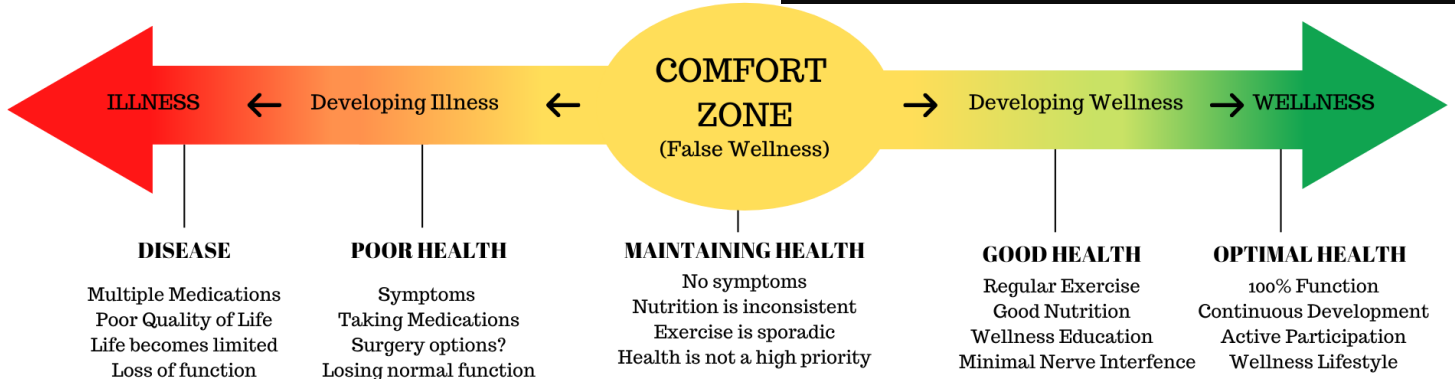
Place an 'X' that denotes where you believe your current level of health to be.
Place an 'O' indicating where you would like your health to be.

WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?
 YES NO

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

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



Journey to Wellness

AUTHORIZATION FOR CARE

I hereby authorize the doctor to work with my condition through the use of acupuncture, A.M.I.T., Class IV laser, chiropractic, cupping, decompression, dry needling, Graston, Nasal Specific technique and/or pulse. as he or she deems appropriate. I clearly understand and agree that all services rendered to 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. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider 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 the Doctor's Office 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 the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: it is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

Initial If Read Above: _____

TERMS OF ACCEPTANCE

When accepting a new client who is seeking acupuncture, A.M.I.T., Class IV laser, chiropractic, cupping, decompression, dry needling, Graston, Nasal Specific technique and/or pulse, it is essential for both the client and the doctor to be working towards the same objective. Chiropractic has only one goal to work toward the cause, not the effect. It is only when the client 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 in the body. This can cause pain or alteration of nerve function and interference of the transmission or nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. 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 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.

Initial If Read Above: _____

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 disclosures for the purposes of treatment, payment, or practice operations 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 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.
- You may request a super bill, documentary of visits by email.

I have read and understood 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 and /or disclosed.

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT (IF MINOR):

SIGNATURE:

DATE:

DISC Style Assessment

EXAMPLE:

	Demanding Assertive	<input type="checkbox"/>	Outgoing Active	<input type="checkbox"/>	Kind Nice Caring	<input checked="" type="checkbox"/>	Proper Formal	<input type="checkbox"/>
1	Firm Strong	<input type="checkbox"/>	Outgoing Active	<input type="checkbox"/>	Gentle Soft Humble	<input type="checkbox"/>	Law-abiding Conscientious	<input type="checkbox"/>
2	Brave Adventurous	<input type="checkbox"/>	Enthusiastic Influencing	<input type="checkbox"/>	Content Satisfied	<input type="checkbox"/>	Compliant By the book	<input type="checkbox"/>
3	Controlling Take charge	<input type="checkbox"/>	Persuading Convincing	<input type="checkbox"/>	Merciful Sensitive	<input type="checkbox"/>	Pondering Wondering	<input type="checkbox"/>
4	Convinced Cocky	<input type="checkbox"/>	Delightful Pleasant	<input type="checkbox"/>	Peaceful Calm	<input type="checkbox"/>	Conservative Inflexible	<input type="checkbox"/>
5	Determined Optimistic	<input type="checkbox"/>	Entertaining Clowning	<input type="checkbox"/>	Shy Mild	<input type="checkbox"/>	Competent Does right	<input type="checkbox"/>
6	Industrious Hard working	<input type="checkbox"/>	Smiling Happy	<input type="checkbox"/>	Timid Soft spoken	<input type="checkbox"/>	Systematic Follows plans	<input type="checkbox"/>
7	Decisive Sure Certain	<input type="checkbox"/>	Friendly Cordial Popular	<input type="checkbox"/>	Obedient Submissive	<input type="checkbox"/>	Careful Cautious	<input type="checkbox"/>
8	Winner Competitive	<input type="checkbox"/>	Admirable Elegant	<input type="checkbox"/>	Diplomatic Peacemaking	<input type="checkbox"/>	Contemplative Thinker	<input type="checkbox"/>
9	Outspoken Opinionated	<input type="checkbox"/>	Inducing Charming	<input type="checkbox"/>	Hospitable Enjoys company	<input type="checkbox"/>	Inventive Imaginative	<input type="checkbox"/>
10	Forceful Strong-willed	<input type="checkbox"/>	Hyper Energetic	<input type="checkbox"/>	Considerate Thoughtful	<input type="checkbox"/>	Perfectionist Precise	<input type="checkbox"/>
11	Challenging Motivating	<input type="checkbox"/>	Talkative Verbal	<input type="checkbox"/>	Steady Dependable	<input type="checkbox"/>	Accurate Exact	<input type="checkbox"/>
12	Zealous Eager	<input type="checkbox"/>	Exciting Spirited	<input type="checkbox"/>	Quiet Reserved	<input type="checkbox"/>	Organized Orderly	<input type="checkbox"/>
13	Will buy on impulse	<input type="checkbox"/>	Will spend as I want	<input type="checkbox"/>	Will wait, no pressure	<input type="checkbox"/>	Will do without, self-controlled	<input type="checkbox"/>
14	Bold Daring	<input type="checkbox"/>	Happy Carefree	<input type="checkbox"/>	Pleasing Kind	<input type="checkbox"/>	Cool Collected	<input type="checkbox"/>
15	Rules need to be challenged	<input type="checkbox"/>	Rules make it boring	<input type="checkbox"/>	Rules make it safe	<input type="checkbox"/>	Rules make it fair	<input type="checkbox"/>
16	Wants more authority	<input type="checkbox"/>	Wants new opportunities	<input type="checkbox"/>	Wants safety, security	<input type="checkbox"/>	Wants clear direction	<input type="checkbox"/>
17	A good delegator	<input type="checkbox"/>	A good encourager	<input type="checkbox"/>	A good listener	<input type="checkbox"/>	A good analyzer	<input type="checkbox"/>
18	Courageous Bold	<input type="checkbox"/>	Animated Laugh out loud	<input type="checkbox"/>	Please others Team player	<input type="checkbox"/>	Correct Exact	<input type="checkbox"/>

INSTRUCTIONS:

To the left are 18 word groupings that are associated with 4 main personality “styles”.

Read the words in each row and mark the word group that is MOST like you with an “M”.

It is important that you **DO NOT** choose what you want to be, or what others think you are, but what you really are in **YOUR** real life.

D

I

S

C

For Office Use Only

M





INFINITY WELLNESS CENTER
Chiropractic & Acupuncture

Consent to Text Messaging Reminders/Missed Appointments

I give permission consent to receive text messages from Infinity Wellness Center through Ring Central:

- (1) Infinity Wellness Center may send text messages in various formats, including but not limited to, text messages about appointment reminders or missed appointments.
- (2) You are the owner or authorized user of the mobile phone number identified below. You will notify us immediately if you are no longer the owner or authorized user of the mobile phone number identified below.
- (3) You are solely responsible for any message and data charges associated with text messaging.

If you do not wish to receive text messages from Infinity Wellness Center, please do not sign this form.

Client Name: _____

Signature: _____

Mobile Phone Number: _____



INFINITY WELLNESS CENTER
Chiropractic & Acupuncture

Empowering Others

Sometimes we take photos in our office to document the progress of results and care. Often, those photos can be used to **empower** and **educate** other families the power of chiropractic/acupuncture/dry needling/cupping/PEMF/AMIT/laser therapy/decompression for similar things going on.

You are answering below on behalf of yourself or your child for these photos to be used for printed or web materials for potential educational opportunities.

_____ Initials to say **YES**

_____ Initials to say **NO**