

Date: \_\_\_/\_\_\_/\_\_\_

## Community Chiropractic Center Health History

Welcome to our office! Thank you for trusting us with your healthcare needs. Our office is focused on providing your family with the highest quality and most professional healthcare possible. Please complete the following health history information in order for us to properly assess your symptoms, function, health care challenges and health care goals. We look forward to a healthy relationship, working together to help you and your family reach your health and wellness goals.

<b>Last Name</b>		<b>First Name</b>		<b>Middle I.</b>
<b>Date of Birth</b> ___/___/___	<b>Age</b>	<b>Male/Female</b>	<b>Social Security Number</b>	
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Home Phone</b> ( ) ( )	<b>Cell Phone</b> ( ) ( )	<b>Cell Phone Provider</b>	<b>Email</b>	
<b>Occupation</b>		<b>Employer's Name</b>		
<b>Emergency Contact</b>		<b>Phone Number</b>		
<b>Marital Status</b> Single Married Divorced Widowed		<b>Spouse's Name (or parent)</b>	<b>Number of Children</b>	
<b>Names, Ages, &amp; Gender of Children</b>				
<b>Who may we thank for referring you?</b>				

## LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did it begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	Y/N	_____
2. _____	_____	_____	_____	Y/N	_____
3. _____	_____	_____	_____	Y/N	_____
4. _____	_____	_____	_____	Y/N	_____
5. _____	_____	_____	_____	Y/N	_____

**HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? Y/N**

**CHIROPRACTOR? Y/N      MEDICAL DOCTOR? Y/N      OTHER? Y/N**  
**WHO AND WHEN?** \_\_\_\_\_

## CIRCLE ALL CURRENT PROBLEMS YOU HAVE

HEADACHES	ASTHMA	CHEST PAIN	SCIATICA	DISC PROBLEM
ANXIETY	IRRITABILITY	LIVER DISEASE	LOW BACK PAIN	GASTRIC REFLUX
DIZZINESS	FREQUENT COLDS	THROAT ISSUES	HIP PAIN	DIFFICULTY SLEEPING
EAR INFECTIONS	MID BACK PAIN	THYROID PROBLEMS	LEG PAIN	SHORT OF BREATH
VERTIGO	SHOULDER PAIN	HEART DISORDERS	KNEE PAIN	ARM PAIN
NAUSEA	ULCERS	DIABETES	LUPUS	MENSTRUAL PAIN
TMJ	DIGESTIVE ISSUES	HEARTBURN	CHRONIC FATIGUE	ARM NUMBNESS
NECK PAIN	DIARRHEA	IRRITABLE BOWEL	FIBROMYALGIA	LEG NUMBNESS
MIGRAINES	HYPERTENSION	BLADDER PROBLEMS	DEPRESSION	INFERTILITY
CHRONIC SINUS	CONSTIPATION	KIDNEY PROBLEMS	ADD/ADHD	PREGNANCY ISSUES
CARPAL TUNNEL	COLIC	WRIST PAIN	ALLERGIES	OTHER _____
ARTHRITIS	EPILEPSY	RINGING IN EAR	NERVOUSNESS	_____

## CIRCLE ANY CONDITION THAT YOU HAVE NOW OR HAVE HAD

STROKE HEART DISEASE CANCER SPINAL SURGERY SEIZURES SPINAL FRACTURES SCOLIOSIS

LIST ALL SURGICAL OPERATIONS AND YEARS \_\_\_\_\_

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

WHEN WAS YOUR LAST AUTO ACCIDENT \_\_\_\_\_

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, DR. & DATE \_\_\_\_\_

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? Y / N FRACTURED A BONE? Y / N

IF YES, PLEASE DESCRIBE \_\_\_\_\_

OTHER TRAUMA: \_\_\_\_\_

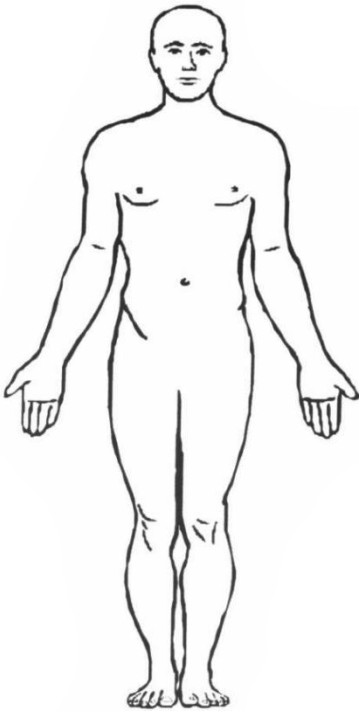
HOW WOULD YOU RATE YOUR HEALTH? Excellent Good Average Fair Poor

WHAT ARE YOU CURRELTLY DOING FOR YOUR HEALTH? \_\_\_\_\_

WHAT DAILY ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS? \_\_\_\_\_

**PLEASE MARK** the areas on the diagram with the following letters to describe your symptoms

R = Radiating   B = Burning   D = Dull   A = Aching   N = Numbness   S = Sharp/Stabbing   T = Tingling



What relieves your symptoms?

---

---

What makes them feel worse?

---

---

Has this ever happened before? \_\_\_\_\_

When? \_\_\_\_\_

### **SOCIAL HISTORY**

1. **SMOKING:**    CIGARS    PIPE    CIGARETTES  
HOW OFTEN?    DAILY    WEEKENDS    OCCASIONALLY    NEVER
2. **EXERCISE / HOW OFTEN**  
 DAILY    WEEKENDS    OCCASIONALLY    NEVER

**\*IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW**

### **WRITTEN CONSENT FOR A CHILD**

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD \_\_\_\_\_

I AUTHORIZE DR. JOEL COX AND ANY AND ALL COMMUNITY CHIROPRACTIC CENTER STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY COMMUNITY CHIROPRACTIC CENTER.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
GUARDIAN SIGNATURE

\_\_\_\_\_  
GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

# **FAMILY HEALTH HISTORY**

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PLEASE PRINT YOUR NAME HERE

<b>CONDITION</b>	<b>SPOUSE</b>	<b>DAUGHTER</b>	<b>SON</b>	<b>MOTHER</b>	<b>FATHER</b>
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

## **INSURANCE INFORMATION**

Even if you are here through a non-referral source such as an external workshop, we are happy to verify your insurance coverage. We will NEVER bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.

Name of Primary Insurance Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured Social Security Number: \_\_\_\_\_

Name of Secondary Insurance Carrier: \_\_\_\_\_

## **RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS**

I authorize and request payment of insurance benefits directly to Joel Cox, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

## **TERMS OF ACCEPTANCE/ CONSENT TO TREATMENT**

The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. Misalignments of the spinal bones which interfere with the nervous system are called SUBLUXATIONS. Subluxations are a misalignment of one or more of the 24 vertebra which come from many causes and prevent various organs, glands, tissues and muscles from functioning properly.

OUR ONLY PRACTICE OBJECTIVE is to find and remove vertebral subluxations. Our only method is specific adjusting to correct neurological subluxations.

Chiropractic does not treat disease or symptoms. The doctor of chiropractic's only goal is to allow the body to function properly and his only means is the correction of the vertebral subluxation.

Please understand that chiropractic is NOT a substitute for medical treatments of any kind. Also, No statement of the chiropractor is intended as medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

When you take a drug or medication there is a risk of dangerous side effects. When any medical test or procedure is performed certain risk is involved. When you walk down stairs, drive a car, or play sports, there is always risk. On that note, chiropractic adjustments, which are always extremely safe and effective (a typical chiropractors malpractice insurance costs less than his car insurance), pose a very tiny degree of risk in certain situations. The most common side effects seen in a small percentage of people are post adjustment muscle soreness. This is comparative to post exercise soreness. This typically subsides quickly. If you do experience any post adjustment sensations please tell the doctor on your next visit. If you have any questions concerning the safety of chiropractic in certain situations, please explain this to the doctor. The doctor will give the utmost to care for you in the safest and most effective manner, just as he would his own family.

I have read the above, all questions regarding the doctor's objectives have been answered to my satisfaction and I understand it fully and undertake chiropractic care on this basis.

### **X-RAY NOTE:**

INIT \_\_\_\_\_ I hereby give my consent to and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am NOT pregnant.

SIGNED \_\_\_\_\_

DATE \_\_\_\_\_

# HIPAA - Health Insurance Portability & Accountability Act

Community Chiropractic Center  
812 N. Main St.  
Greer, SC 29651  
(864) 469-7979

The following is an explanation of our Privacy Policies for this office.

- Our office does NOT distribute or make available to any outside source your private personal health information.
- Your information is secure and is used only in submitting claims to third party carriers for payment of services.
- I give COMMUNITY CHIROPRACTIC CENTER permission to adjust me in a semi-closed room setting where other patients and office staff may be able to overhear some of my PHI during the course of care. This semi-closed room environment is used for ongoing care, and is not the environment used for taking patient histories, performing examinations, or presenting report of findings, as these procedures are completed in a private, confidential setting.
- I give COMMUNITY CHIROPRACTIC CENTER our permission to use my name on the welcome board, referral board, birthday board, prize winning notices, and community information (i.e. newspaper clippings).
- I give COMMUNITY CHIROPRACTIC CENTER permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If COMMUNITY CHIROPRACTIC CENTER contacts me by phone, I give them permission to leave a message on my voice mail or answering machine.
- A family member can be present when hearing the results of your exam and tests.

A more detailed explanation of our policies is available for you to read and take a copy with you. Please ask the front desk for it.

By signing, I have read, understand and agree to the privacy policies for this office. I can take a copy for my records. I understand that if I choose not to participate that I can and will notify the Community Chiropractic Center staff of my concerns in writing.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PRINTED** \_\_\_\_\_