ADULT HEALTH HISTORY

Today's Date_____

ABOUT THE PATIENT

Name _____ Age _____ Date of Birth _____

Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Home phone (_____) _____ Cell phone (_____) _____

Occupation _____ E-mail _____

Emergency Contact Name_____ Emergency Contact phone (_____)_____

Primary Provider's Name _____ Phone (_____)_____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel we can address for you? _____

_____

What is your chief complaint? _____

Date of Onset: _____

On a scale of 0-10, with 0 meaning perfect and 10 meaning hospitalization, please indicate how you feel:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Onset of symptoms was: ☐ Sudden ☐ Gradual ☐ Injury ☐ Chronic ☐ Auto

Describe Your Pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Radiating ☐ Throbbing ☐ Other

Duration of symptoms: ☐ Minutes ☐ Hours ☐ Days ☐ Months ☐ Years

☐ Other _____

Pattern of symptoms: ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%) ☐ Cyclical

What makes your symptoms better? _____

What makes your symptoms worse? _____

Are your symptoms affecting your quality of life? ☐ Yes ☐ No

Check all that apply

☐ Work	☐ Exercise/Sports	☐ Walking
☐ Social Activities	☐ Sleep	☐ Attention/Focus
☐ Relationship	☐ Eating	☐ Daily Routine

Please describe how these concerns affect you. _____

_____

Have you had anything like this before? ☐ Yes ☐ No

If so, when? _____

Any other health concerns? _____

EXPECTATIONS OF CARE

The primary system in the body, which coordinates health, is the NERVOUS SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVOUS SYSTEM. A MISALIGNMENT in the SPINE and NERVOUS SYSTEM is a condition called a VERTEBRAL SUBLUXATION. A VERTEBRAL SUBLUXATION results in nerve malfunction, which results in less communication between the affected NERVES and the function of the BODY.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to, how they may relate to your present spinal, nerve, and health status and whether they may have caused **Vertebral Subluxations** to occur.

I would like to experience the following benefits from Chiropractic Care:

Check all that apply

- ☐ Symptomatic relief of pain or discomfort
- ☐ Correction of the cause of the problem as well as relief of symptoms
- ☐ Prevention of future problems
- ☐ Healthier spine and nerve system
- ☐ Optimal health on all levels
- ☐ Nutritional Support/Lifestyle Counseling
- ☐ OTHER_____

CHEMICAL STRESS

Have you:

☐ Experienced any significant illnesses, difficulties, or trauma? _____

☐ Take(n) any drugs/medications for current condition? _____

☐ Smoked or consumed alcohol? _____

☐ Been exposed to second hand smoke?_____

☐ Taken antibiotics? Explain _____

☐ Currently taking medication? Explain _____

☐ Currently taking any supplements (Vitamins/Probiotics)? Explain _____

☐ Had allergies (seasonal, food, etc)? Explain _____

-What treatments have you used? _____

PHYSICAL STRESS

Are/Have you:

☐ Been hospitalized? Explain: _____

☐ Had a severe trauma? Explain: _____

☐ Been in an automobile accident? Explain/Date: _____

☐ Fractured a bone or dislocated a joint? Explain: _____

☐ Had a chronic illness? Explain: _____

☐ Had surgery? Explain: _____

What physical activities do you participate in? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are currently experiencing any of the emotional stresses below:

☐ Employment	☐ Loss of a loved one	☐ Divorce	☐ Relocation
☐ Lifestyle change	☐ Caretaker for loved one	☐ Loss of a pet	☐ New Baby
☐ Anxiety	☐ Addiction	☐ Other: _____	

HEALTH CARE PRACTITIONER HISTORY

Have you ever received chiropractic care? ☐ Yes ☐ No Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers?

Check all that apply	☐ Medical Physician	☐ Naturopath	☐ Acupuncturist	☐ Homeopath
	☐ Massage Therapist	☐ Psychotherapist	☐ Energy Healer	☐ Other

Reason _____

_____

_____

FINANCES

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ HSA Card

PLEASE READ AND SIGN

1. I acknowledge Innate Chiropractic & Wellness has informed me they are not guaranteeing insurance assignment. Therefore, they cannot guarantee claims for any services rendered to me by Dr. Rachel Settles or Dr. Sean Padgett. I clearly understand and agree all services rendered are charged directly to me and I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. All services rendered will be paid in full each visit, each month, or when packages are purchased.
2. I have been informed that a copy of Innate Chiropractic & Wellness *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review at the office
3. I consent to receive communication from Innate Chiropractic & Wellness via email, postal mail, text and telephone messaging in connection with my care. ☐ Yes ☐ No
   If I should withdraw my consent, I will notify the office in writing.
4. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Rachel Settles or Dr. Sean Padgett, of Innate Chiropractic & Wellness, permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____

Signature _____ Date: _____

Dr. Signature _____ Date: _____

Thank you for choosing Innate Chiropractic & Wellness.

We look forward to helping you.