Adult Health Record

About You

NAME:

ADDRESS: CITY: STATE/ZIP:

HOME PHONE: CELL PHONE:

MARITAL STATUS (circle): S M D W EMAIL:

DOB: GENDER: SSN:

EMERGENCY CONTACT: RELATIONSHIP: PHONE:

EMPLOYER: POSITION:

JOB DUTIES: WORK PHONE:

EMPLOYER ADDRESS: CITY: STATE/ZIP:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

☐ MYSELF ☐ SPOUSE ☐ PARENT ☐ WORKERS COMP ☐ AUTO INSURANCE ☐ MEDICARE ☐ HEALTH INSURANCE

NAME:

ADDRESS: CITY: STATE/ZIP:

PHONE: FAX:

Health Concern(s)

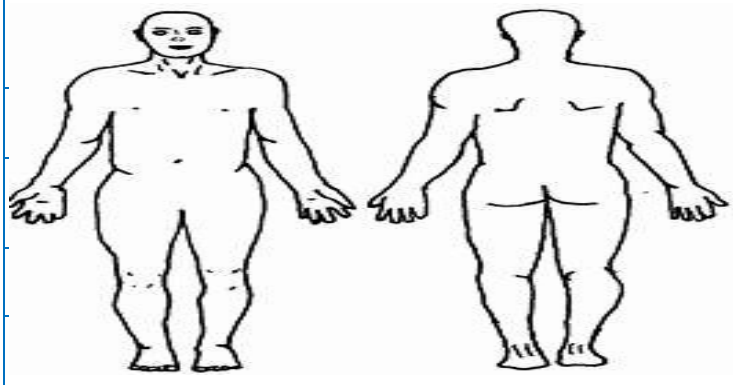
REASON FOR TODAY'S VISIT:

WHEN DID IT BEGIN?

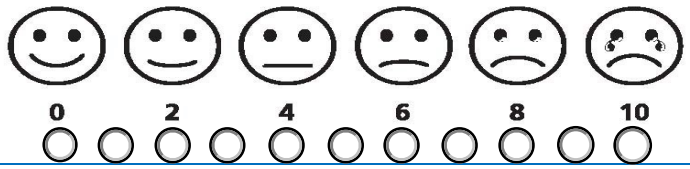
INSTRUCTIONS: *Please mark the area and type of pain using:*

N = Numbness **P** = Pain **A** = Ache

T = Tingling **S** = Stiffness/Soreness



RATE THE INTENSITY OF YOUR CURRENT SYMPTOMS:



HOW LONG DOES INTENSITY LAST:

HAS THE CONDITION:

☐ GOTTEN WORSE ☐ STAYED CONSTANT ☐ COME AND GO

WHAT MAKES CONDITION BETTER:

WHAT MAKE S CONDITION WORSE:

DESCRIBE YOUR CONDITION'S EFFECT ON YOUR PHYSICAL ABILITIES

1 = No effect **2** = Painful (I can do it) **3** = Painful (I'm limited) **4** = unable to perform

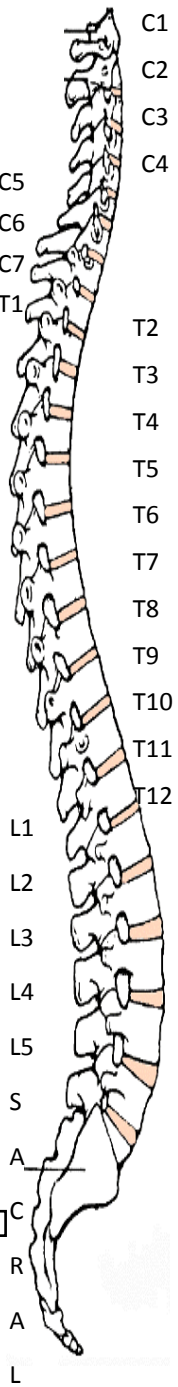
Lifting/carrying _____	Climbing Stairs _____	Static Sitting _____	Self Care (Bathing) _____	Driving _____
Chores/Yard Work _____	Change Position (Stand to Sit) _____	Static Standing _____	Self Care (Dressing) _____	Computer _____
Walking _____	Change Position (Sit to Stand) _____	Lifting weights _____	Sexual Activities _____	Job Duties _____

List any other activity not above and rate_____

Previous Treatment

HAVE YOU SEEN ANY OTHER DOCTOR FOR CONDITION?	
DOCTOR'S NAME:	PHONE:
IS HE/SHE A CHIROPRACTOR? ☐ YES ☐ NO	IF NO, WHAT TYPE OF DOCTOR:
TYPE OF TREATMENT:	HOW LONG UNDER CARE:
RESULTS OF TREATMENT:	
HAVE YOU BEEN ADUSTED BY A CHIROPRACTOR BEFORE? ☐ YES ☐ NO	REASON FOR THOSE VISITS:
CHIROPRACTORS NAME: PHONE:	DATE OF LAST VISIT:

General Health Status



Sore Throat ☐
Neck Pain/Stiffness ☐
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 ☐

Middle Back Pain ☐
Congestion ☐
Difficulty Breathing ☐
Bronchitis ☐
Pneumonia ☐
Gallbladder Conditions ☐
Stomach Problems ☐
Ulcers/Colitis ☐
Gastritis ☐
Kidney Problems ☐

Constipation ☐
Colitis ☐
Diarrhea ☐
Gas Pain ☐
Irritable Bowel ☐
Bladder Problems ☐
Menstrual Problems ☐
Low Back Pain ☐
Pain or Numbness in legs ☐
Reproductive Problems ☐

Please circle AND check the health concerns or conditions you may be experiencing now or have in the past. Every concern relates to an area of the spine and nerve function.

☐ PINS/NEEDLES	☐ LOSS OF SLEEP	☐ ARTHRITIS	☐ CHANGE IN SENSATIONS
☐ HIGH/LOW BLOOD PRESSURE	☐ HEART SURGERY/ PACEMAKER	☐ CANCER	☐ SURGERIES
☐ DIABETES	☐ ASTHMA	☐ HIV/AIDS	☐ HEPATITIS
☐ RHEUMATIC FEVER	☐ TUBERCULOSIS	☐ OSTEOPOROSIS	☐ CONGENTAL HEART DEFECT
☐ THYROID PROBLEMS	☐ LOW ENERGY	☐ CHANGE IN APPETITE	☐ SUDDEN WEIGHT GAIN/ LOSS
☐ OTHER:			

FOR WOMEN ONLY

ARE YOU PREGNANT? ☐ YES ☐ NO
IF YES, WHEN IS YOUR DUE DATE?
ARE YOU NURSING? ☐ YES ☐ NO
ARE YOU TAKING BIRTH CONTROL? ☐ YES ☐ NO
DO YOU:
EXPERIENCE PAINFUL PERIODS? ☐ YES ☐ NO
HAVE IRREGULAR CYCLES? ☐ YES ☐ NO

Medications *Please write name of medications.*

❑ CHOLESTEROL	❑ BLOOD PRESSURE
❑ STIMULANTS/TRANQUILIZERS	❑ BLOOD THINNERS
❑ BONE DENSITY	❑ PAIN KILLERS (INCLUDING ASPIRIN)
❑ MUSCLE RELAXERS	❑ INSULIN
❑ VITAMINS/SUPPLEMENTS	❑ OTHER

Consent to Chiropractic Care

Please take a moment to read and initial all of the following statements:

_____ The practice of chiropractic focuses on the relationship between structure (of the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. I understand chiropractors are the only healthcare practitioners trained to identify and correct the cause of health challenges which arise when misalignments of the spine (vertebral subluxations) disrupt neurological communications between the brain and the rest of the body. I understand these subluxations create swelling and muscle spasms around vertebrae of the spine, causing inflammation, decreased range of motion, pain, decreased nerve function, and overall lessening of the body's innate ability to express its maximum health potential. I understand extremity misalignments may be associated to vertebral subluxations.

_____ I understand chiropractors use a specific application of forces to facilitate the body's correction of vertebral subluxations called an adjustment. I hereby request and consent to the performance of chiropractic adjustments and all physiotherapeutic applications on me deemed necessary by Dr. Lakeia M. Manor. The chiropractic adjustments and procedures I receive is provided for the following purposes: prevent/treat neuromusculoskeletal injuries, reduce pain, decrease muscle spasms, increase range of motion and flexibility, improve circulation, and enhance overall health potential. I understand some physiotherapeutic applications may be performed on me by her assistant(s).

_____ I am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some extremely rare risks to treatment; including, but not limited to: temporary soreness, dizziness, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect Dr. Manor to be able to anticipate and explain all risks and complications. Further, I wish to rely on her to exercise judgment during the course of the procedure which she feels are in my best interests at the time, based upon the facts then known. I understand these risks occur in extremely rare incidences and therefore, it is my responsibility to immediately notify Dr. Manor of any unusual signs or symptoms I may experience. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of evaluation, care or treatment.

_____ Because chiropractic services should not be performed under certain medical conditions, I affirm I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Dr. Manor updated as to any changes in my medical profile. I understand that there shall be no liability held on Dr. Lakeia M. Manor, Manor Chiropractic, and/or its staff should I fail to do so. I also understand that Dr. Manor reserves the right to refuse to perform chiropractic services on anyone whom she deem to have a condition for which it is contraindicated. I understand Dr. Manor does not offer to treat or diagnose any disease or condition other than vertebral subluxations and associated extremity misalignments. Nor does she offer advice regarding treatment prescribed by others.

_____ I understand that accidents to include motor vehicle, slips/falls, etc. can significantly change my overall health. I agree to consult with Dr. Manor to update my new current health status and make appropriate referrals as needed. I understand that she may elect to modify or suspend future treatments.

_____ I understand in an effort of better patient flow, Dr. Manor may elect to use an open-adjustment and/or treatment environment where several patients are placed in one area. I understand she will keep table talk to general chiropractic education and I may discuss my condition in a private setting. I understand I can elect to have my adjustment and/or treatment performed in a private setting by discussing this with Dr. Manor beforehand.

_____In event x-rays are taken of me, it is understood and agreed payments to Dr. Manor 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 of this office.

I , _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction. By signing this form, I consent to chiropractic care. I hereby waive and release Dr. Lakeia M. Manor, Manor Chiropractic, and/or its staff from any and all liability, past, present, and future relating to my care. I agree that Dr. Manor and Manor Chiropractic reserve the right to interpret, change, modify, amend or rescind policies in whole, or in part, at any time without prior notice.

Signature: Sign in office _____ Date: Date in office _____

Notice of Privacy Practices

Protecting the privacy of your personal health information (PHI) 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 its staff.

I understand, 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.*

I am provided the right to request confidential communications or that a communication of PHI is made by alternative means. I wish to be contacted in the following manner (check all that apply):

Home Telephone: ☐ *Ok to leave a message with detailed information* ☐ *Leave message with call back number*

Cell Telephone: ☐ *Ok to leave a message with detailed information* ☐ *Leave message with call back number only* ☐ *Text messages*

Work Phone: ☐ *Ok to leave a message with detailed information* ☐ *Leave message with call back number*

Written: ☐ *Ok to mail to home address* ☐ *Ok to mail to office work address* ☐ *Ok to fax to this number* _____

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I understand I can request, in writing, to restrict how my personal information is used and/or disclosed. A photocopy of this notice shall be considered as effective and valid as the original.

Print Name: _____ **Sign:** Sign in office _____ **Date:** Date in office _____

Assignment of Benefits For Direct Payment to Manor Chiropractic, LLC

I hereby instruct and direct _____ Insurance Company/Attorney (primary) and _____(secondary if applicable) Insurance Company to make check(s) payable and mail directly to:

Manor Chiropractic, LLC

Dr. Lakeia M. Manor, DC

P.O. Box 24102

Savannah, GA 31403

I authorize the doctor to release all information pertinent to my case necessary to communicate with personal physicians and other healthcare providers and any insurance company, adjuster or attorney involved in case and to secure the payment of benefits. If my current policy prohibits direct payment to the above, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

c/o Manor Chiropractic, LLC

Dr. Lakeia M. Manor

P.O. Box 24102

Savannah, GA 31403

the benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original.

Print Name: _____ **Sign:** Sign in office _____ **Date:** Date in office _____