POINTE VILLAGE CHIROPRACTIC

Confidential Health Record

Thank you for choosing Pointe Village Chiropractic for your medical care.

Please complete this Health Record; if something does not apply write N/A in the blank.

NAME: _____ BIRTHDATE: _____ AGE: _____ Acct #: _____

GENDER: ☐ Male ☐ Female **MARITAL STATUS**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

RACE: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Middle Eastern LANGUAGE(S) SPOKEN: _____

ADDRESS: _____

NUMBER & STREET, CITY STATE ZIP

Cell Phone: _____ **Home Phone**: _____

E-mail: _____

PREFERRED Contact Method: ☐ E-mail ☐ Phone (Cell, Home, Work) circle one

EMERGENCY CONTACT: _____

Relationship: _____ Phone:_____

HOW DID YOU HEAR OF OUR OFFICE: _____

Social Habits:

Tobacco use: ☐ Light ☐ Social ☐ Moderate ☐ Heavy ☐ Non-Smoker

Alcohol use: ☐ Social ☐ Light ☐ Moderate ☐ Heavy ☐ Alcoholic
☐ Recovering Alcoholic ☐ Does Not Drink

Have you used recreational drugs: (Marijuana, Crack, Cocaine, etc.)?
☐ No use of Recreational Drugs ☐ Light ☐ Moderate ☐ Heavy ☐ Drug Addicted
☐ Recovering Drug Addict

EMPLOYER INFORMATION:

TYPE OF WORK YOU DO:_____

EMPLOYER: _____

EMPLOYER ADDRESS:

_____

STREET, CITY STATE ZIP

☐ Full-time ☐ Part-time ☐ Homemaker ☐ Retired ☐ Student

☐ Unemployed

☐ 0-20 hours per week ☐ 20 to 40 hours per week

☐ 40 to 50 hours per week ☐ 60 to 70 hours per week

☐ Mostly Sitting ☐ Mostly Standing ☐ Mostly Walking

☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

☐ Computer Work ☐ Repetitive Activities ☐ Heavy Telephone Use

Patient Name: _____ Date: _____ Acct #: _____

Allergies
Surgical History
Medications
Are you pregnant: ☐ Yes ☐ No
Have you seen anyone else for this condition? If yes who?
Primary Complaint:
Secondary Complaint:

Past Family and Personal Medical History

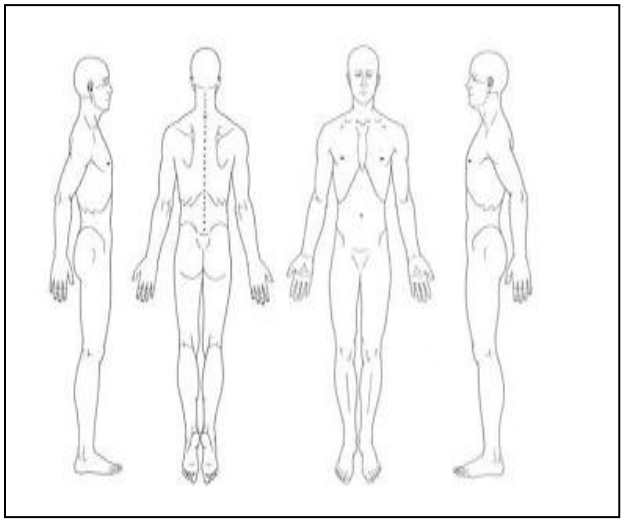
	Self	Mother	Father	Sister	Brother
Arthritis					
Cancer Type:					
Chronic Pain					
Depression					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Migraine Headaches					
Hypothyroidism					
Hyperthyroidism					
Multiple Sclerosis					
Hypoglycemia					
Asthma					
Bleed easily					
Rheumatoid Arthritis					
Osteoarthritis					
Other:					
Other:					
Other:					

Accidents/Trauma:

	Date(s) of accident(s)	Permanent injury?	Hospitalization	If permanent injury explain:
☐ No previous trauma				
☐ Automobile				
☐ Slip and Fall				
☐ Motorcycle				
☐ Boating				

What do you relate your symptoms to?

☐ No Known Injury
☐ Auto Accident
☐ Bending Down
☐ Exercising
☐ Fall
☐ Lifting
☐ Playing with Children
☐ Pushing
☐ Reaching/Pulling
☐ Shoveling Snow
☐ Twisting
☐ Yardwork
☐ Auto Accident
☐ Workmans Comp Injury
☐ Other: _____



Please circle on the diagram above where your pain is.

When did your symptoms first occur?

	Less than 1	1	2	3	4	5	6	7	8	9	10	More than 10
Hour (s)												
Day (s)												
Week (s)												
Month (s)												
Year (s)												

Patient Name: _____ Date: _____ Acct. #: _____

Please indicate pain level for each affected body part with 0 being no pain and 10 being the worst pain possible.

Pain level	Head	Neck	Midback/ Chest	Low back/ Hip/buttock	Other:
0	☐	☐	☐	☐	☐
1	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐
6	☐	☐	☐	☐	☐
7	☐	☐	☐	☐	☐
8	☐	☐	☐	☐	☐
9	☐	☐	☐	☐	☐
10	☐	☐	☐	☐	☐

Please indicate for each body part affected how often you get pain.

Frequency	Head	Neck	Midback/ chest	Low back/ Hip/buttock	Other
Constant	☐	☐	☐	☐	☐
Daily	☐	☐	☐	☐	☐
Comes & Goes	☐	☐	☐	☐	☐
Less than 1 x per week	☐	☐	☐	☐	☐
1-3 x per week	☐	☐	☐	☐	☐
4-6 x per week	☐	☐	☐	☐	☐

For each body part affected, please indicate the types of symptoms you have. Check all that apply

Type of Symptom	Head	Neck	Midback/ Chest	Low back/ Hip/buttock	Other
Achy	☐	☐	☐	☐	☐
Burning	☐	☐	☐	☐	☐
Dull	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐
Numb	☐	☐	☐	☐	☐
Radiating	☐	☐	☐	☐	☐
Sharp	☐	☐	☐	☐	☐
Shooting	☐	☐	☐	☐	☐
Stabbing	☐	☐	☐	☐	☐
Stiff	☐	☐	☐	☐	☐
Throbbing	☐	☐	☐	☐	☐
Tight	☐	☐	☐	☐	☐
Tingling	☐	☐	☐	☐	☐
Vertigo	☐	☐	☐	☐	☐

For each body part affected, please indicate how long your symptoms last when they occur.

Duration (When you get pain how long does it last?)	Head	Neck	Midback/ Chest	Low back/ Hip/buttock	Other
Several hours	☐	☐	☐	☐	☐
About an hour	☐	☐	☐	☐	☐
30 minutes	☐	☐	☐	☐	☐
15 minutes	☐	☐	☐	☐	☐
Short spurts	☐	☐	☐	☐	☐
Only when active	☐	☐	☐	☐	☐
Only at night	☐	☐	☐	☐	☐
Only in AM	☐	☐	☐	☐	☐
Variable duration	☐	☐	☐	☐	☐
Difficult to determine	☐	☐	☐	☐	☐
N/A (i.e. constant)	☐	☐	☐	☐	☐

Patient Name: _____ Date: _____ Acct. #: _____

For each body part affected, please indicate what aggravates your symptoms. Check all that apply

Aggravating Factor	Head	Neck	Midback/ Chest	Low back/ Hip/buttock	Other
Any movement	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Exercising	☐	☐	☐	☐	☐
Lifting > 10lbs	☐	☐	☐	☐	☐
Lifting > 20lbs	☐	☐	☐	☐	☐
Lifting > 50lbs	☐	☐	☐	☐	☐
Lifting weights	☐	☐	☐	☐	☐
Looking up	☐	☐	☐	☐	☐
Looking down	☐	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	☐
Lying on side	☐	☐	☐	☐	☐
Lying on stomach	☐	☐	☐	☐	☐
Nothing specific	☐	☐	☐	☐	☐
Pulling	☐	☐	☐	☐	☐
Pushing	☐	☐	☐	☐	☐
Reaching forward	☐	☐	☐	☐	☐
Reaching up	☐	☐	☐	☐	☐
Rising from laying	☐	☐	☐	☐	☐
Rising from seated	☐	☐	☐	☐	☐
Running	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
How long can you sit before pain starts?_____					
Standing	☐	☐	☐	☐	☐
How long can you stand before pain starts? _____					
Support brace	☐	☐	☐	☐	☐
Turning head left	☐	☐	☐	☐	☐
Turning head right	☐	☐	☐	☐	☐
Twisting	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
How long/far can you walk before pain starts? _____					

For each body part affected, please indicate what relieves your symptoms. Check all that apply

Relieving Factors	Head	Neck	Midback/ Chest	Low back/ Hip/buttock	Other
Chiropractic care	☐	☐	☐	☐	☐
Class IV Summus Laser	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Heat	☐	☐	☐	☐	☐
Ice	☐	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	☐
Massage	☐	☐	☐	☐	☐
Movement	☐	☐	☐	☐	☐
Nothing	☐	☐	☐	☐	☐
Orthotics	☐	☐	☐	☐	☐
Over the counter Meds	☐	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐	☐
Pillows	☐	☐	☐	☐	☐
Prescription Meds	☐	☐	☐	☐	☐
Resting	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Stretching	☐	☐	☐	☐	☐
Support Brace	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

Patient Name: _____ Date: _____ Acct. #: _____

Review of Symptoms, Please check all that apply, make sure that you check no symptoms if it applies in each category.

CONSTITUTIONAL SYMPTOMS?

- ☐ No symptoms
- ☐ Decreased activity level
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Loss of energy
- ☐ Uncontrolled sweating.

PSYCHIATRIC SYMPTOMS?

- ☐ No Symptoms
- ☐ Irritability
- ☐ Depression
- ☐ Disturbed sleep
- ☐ Suicidal thoughts
- ☐ Anxiety
- ☐ Nervousness

GENITOURINAY SYMPTOMS?

- ☐ No symptoms
- ☐ Dysuria (Pain with urination)
- ☐ Frequent urination
- ☐ Urgency
- ☐ Losing control/incontinence
- ☐ Blood in urine
- ☐ Bowel dysfunction

ENDOCRINE SYMPTOMS?

- ☐ No symptoms
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other thyroid problems

HEAD & ENT SYMPTOMS?

- ☐ No symptoms
- ☐ Changes in head dimensions
- ☐ Blurred or Double vision
- ☐ Earaches
- ☐ Recent hearing loss
- ☐ Chronic ear infections
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Difficulty swallowing

CARDIOVASCULAR SYMPTOMS?

- ☐ No symptoms
- ☐ Chest pain
- ☐ Palpations
- ☐ Dizziness
- ☐ Dyspnea (uncomfortable breathing)
- ☐ Hypertension (high blood pressure)
- ☐ Hypotension (low blood pressure)
- ☐ Excessive bruising
- ☐ Lower extremity edema

RESPIRATORY SYMPTOMS?

- ☐ No Symptoms
- ☐ Coughing
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Apnea
- ☐ Emphysema
- ☐ Pneumonia ☐ Wheezing

GASTROINTESTINAL SYMPTOMS

- ☐ No Symptoms
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Ulcer
- ☐ Heartburn

MUSCULOSKELETAL SYMPTOMS?

- ☐ No symptoms
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Neck pain
- ☐ Back problems
- ☐ Hip disorders
- ☐ Knee injuries
- ☐ Foot/Ankle pain
- ☐ Shoulder problems
- ☐ Elbow/wrist pain
- ☐ TMJ issues
- ☐ Poor posture

INTEGUMENTARY SYMPTOMS?

- ☐ No Symptoms
- ☐ Rash
- ☐ Easy bruising
- ☐ Gum bleeding
- ☐ Hyper/Hypo pigmentation
- ☐ Excessive Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Excessive hair loss

IMMUNOLOGIC SYMPTOMS?

- ☐ No Symptoms
- ☐ Enlarged lymph nodes
- ☐ Hives
- ☐ Hay fever
- ☐ Persistent infections

NEUROLOGIC SYMPTOMS?

- ☐ No Symptoms
- ☐ Numbness & Tingling
- ☐ Seizures
- ☐ Abnormal sensory feelings in extremities
- ☐ Loss of memory
- ☐ Trigeminal neuralgia
- ☐ Neuralgia
- ☐ Fibromyalgia
- ☐ Pins and needles feeling

Patient Name: _____ Date: _____ Acct. #: _____

Informed Consent for Care Pointe Village Chiropractic

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed Consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives and potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use or hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed and there is no promise of a cure. As with all types of health care interventions, there are some risks to care. Including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by the arterial dissections have been associated with over 72 everyday activities such as sneezing, driving and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor of chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and the risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent, I appreciate that it is not possible to consider every possible complication of care. I have also had the opportunity to ask questions about its content and by signing below, I agree with the current or future recommendations to receive chiropractic care as deemed appropriate for my circumstances. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient or Guardian Signature: _____ Date: _____

Patient Name: _____ Date: _____ Acct. #: _____

Notice of Privacy Practices

I acknowledge that Pointe Village Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Pointe Village Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in performance of health care operations of Pointe Village Chiropractic.
The Notice of Privacy Practices for Pointe Village Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Pointe Village chiropractic's duties with respect to my protected health information.
Pointe Village Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or ask for one at the time of my next appointment.

Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

I, hereby consent and state my preference to have my physician, and other staff at Pointe Village Chiropractic, communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave appointment reminders and/or my private health information at the following: (please fill-in the ones you agree to):

Email:_____ ☐ appointment reminders ☐ my private health information

Cell Phone number: _____ ☐ appointment reminders ☐ my private health information

Data Provider: ☐ AT&T ☐ Verizon ☐ Metro PCS ☐ Cricket ☐ Nextel ☐ X-Finity ☐ T-Mobile ☐ US Cellular ☐ Virgin Mobile ☐ Other: _____

How far in advance would you like your text reminder: ☐ 5 min, ☐ 10min ☐ 15 min ☐ 30min ☐ 45min ☐ 1 hour ☐ 2 hours ☐ 4 hours ☐ 1 day ☐ 2 days

☐ I prefer not to receive e-mail or text at this time.

I have the right to revoke this consent, in writing, except to the extent that Pointe Village Chiropractic has taken action in reliance on this consent. PATIENT ACKNOWLEDGEMENT
By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____
Signature of Patient or Personal Representative Date

Revised: 09/30/2023