Yaeger Chiropractic & Nutrition

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Adult Health History Intake Form

Last Name:__________ First Name:__________ Date of Birth:__________ Age:______ Sex: ________

Height:__________ Address:__________ City:__________ St:______ Zip:__________

Email:__________ Contact #: __________

Occupation:__________ Marital Status: S M D W

Referred by:__________ Today's Date: __________

PRESENT HEALTH CONCERNS Please list most important health concerns in their order of significance

1. __________
2. __________
3. __________
4. __________

CURRENT MEDICAL HISTORY

MEDICATIONS: Please list all medication + over the counter medications that you are taking with dosages.

1.__________ 4. __________
2.__________ 5.__________
3.__________ 6.__________

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1.__________ 4. __________
2.__________ 5.__________
3.__________ 6.__________

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications:__________
2. Environment: __________
3. Food: __________

FEMALE ONLY

Are you pregnant:_______________________________________Nursing? ____________________________________

Date of last onset menstrual cycle: ____

Any gynecologic surgeries: (Hysterectomy, endometriosis, ovarian cysts) ________________________________

Menstrual cycle Do you have regular monthly cycles? Y N

How often:________________________________How many days do you cycle: ___________________________

Circle any symptoms that you may experience associated with your period

Cramping *Bloating* *Mood Swings* *Cravings* *Heavy Bleeding* *Back pain* *Clotting* *Headaches*

BIRTH CONTROL: Are you sexually active with: Men Women Both

What form of contraception/birth control are you using (Check all that apply)

□ Withdrawal □ Condom □ The Pill □ The Shot (Depo-Provera) □ The Ring □ Implants □ The Patch

□ Fertility Awareness Method □ The Sponge □ Spermicide □ Diaphragm □ Cervical Cap

PAST MEDICAL HISTORY

ILLNESSES: (Circle and indicate age of illness OR mark C for current)

Acne:	Yes/Age:	Ear Infections:	Yes/Age:
ADD:	Yes/Age:	Eating Disorders:	Yes/Age:
ADHD:	Yes/Age:	Eczema:	Yes/Age:
Alcohol use:	Yes/Age:	Headaches:	Yes/Age:
Allergies:	Yes/Age:	Head lice:	Yes/Age:
Asthma:	Yes/Age:	Mononucleosis:	Yes/Age:
Behavior problems:	Yes/Age:	Pink eye:	Yes/Age:
Bronchitis	Yes/Age:	Pneumonia:	Yes/Age:
Constipation:	Yes/Age:	Sinus Infection:	Yes/Age:
Depression/ Anxiety	Yes/Age:		
Diarrhea	Yes/Age:		
Drug Abuse	Yes/Age:		

Please comment o any illnesses indicated above: ____

SOCIAL HISTORY

NUTRITIONAL HISTORY:

What is a typical breakfast____
What is a typical lunch ____
What is a typical dinner ____
What are typical snacks ____
How many glasses of water do you drink each day ______________________________
Do you have any special dietary restrictions:
____

EXERCISE:
Do you exercise regularly? □ Yes □ No
What type/activity____________________How long ________________

How often____________________

SLEEP:
How many hours of sleep do you get at night on average ______________________________
Do you have trouble falling asleep? □ No □ Yes/Why ______________________________
How often do you wake up in the middle of the night and for what reasons ____________________
____
Do you have trouble waking up? □ No □ Yes/Why ______________________________
Do you feel rested when you wake up? □ Yes □ No/Why ______________________________

ENERGY AND STRESS:
How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?
How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?
How do you cope with stress?

TRAVEL HISTORY:

Identify any foreign travel and indicate year of travel:

Place:____________________Year__________Place:________________Year:____________

SOCIAL HISTORY

SUBSTANCE USE:
Identify any substances you have used and circle whether in the past (P) or are currently using

Soda: P C Type/Freq:________________

Coffee: P C Type/Freq:________________

Alcohol: P C Type/Freq:________________

Tobacco: P C Type/Freq __________

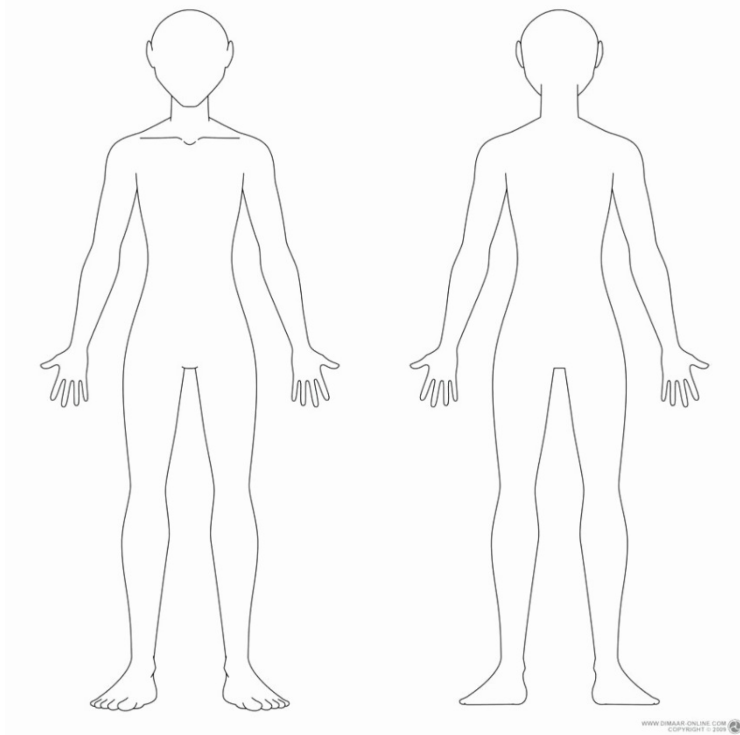
Recreational Drugs: P C Type/Freq __________

Other: P C Type/Freq __________

FAMILY HISTORY

Please place a "C" for current or "P" for past in the box next to each condition as it applies to your family members.

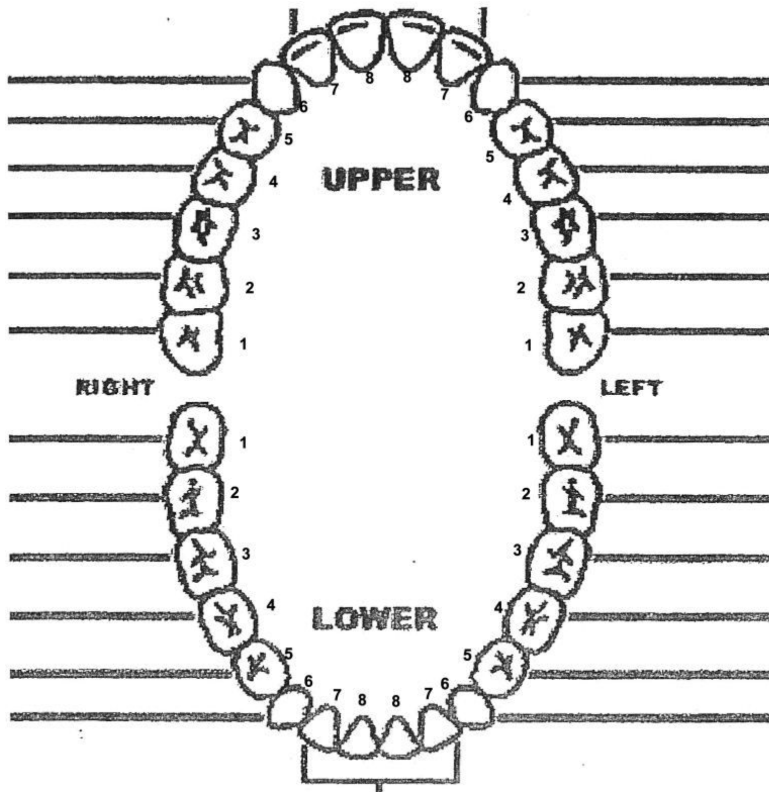
	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism							
Allergies							
Anemia							
Arthritis							
Asthma							
Cancer							
Depression							
Diabetes							
Drug Addiction							
Eczema							
Epilepsy							
Headaches							
Heart Disease							
Hepatitis							
High Blood							
Kidney Disease							
Stroke							
Tuberculosis							



Please draw a zigzag over area where you have scars, tattoos, stretch marks, etc. Please note age you got the scar.

Please circle the location of any surgeries, including expiatory surgeries, laparoscopies, etc.

Please put a square around any internal metal objects, such as surgical.



Please fill out the chart by briefly describing what kind of dental work you had done on each tooth and the approximate age. Please include the following: ***Silver fillings, Composite or Porcelain fillings, Gold fillings or crowns, Root canals, Veneers, Bridges, Dentures, Extracted teeth, etc.***

HIPAA PRIVACY ACT FORM

Release of information for Reimbursement. To the extent necessary to obtain reimbursement, the Facility may disclose any portion of the patient's record including, but not limited to, insurance companies, healthcare service plans, workers compensation carriers, social security administration, and peer review organizations.

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account of the facility in accordance with regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Assignment of insurance benefits: The undersigned authorizes, whether he/she signs agent or as patient direct payment to the facility of any insurance benefits otherwise payable to the undersigned for services rendered as a rate not to exceed the facility's usual and customary charges. It is agreed that the payment to the facility, pursuant to the authorization, by an insurance company Health Care Services plan shall discharge said insurance company Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not converted by this assignment

Health Care Service Plans: The Facility has contracted with multiple Health Care Service Plans, It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services as the Facility, The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible
co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health care Service Plan to the Facility. For non-emergency services if is the patient's responsibility to ensure/his/her Plan authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergency services will be considered a denial for a non-covered benefit and payable by the undersigned.

The Undersigned acknowledges he/she understands the Notice of Privacy Practice and he/she has received a copy of the Notice of Privacy Practices. The undersigned acknowledges he/she understands the Financial Agreement, Assignment of Insurance benefits Health Care Services Plan obligation and all the other application provisions above and received a copy thereof, and is the patients, the patient’s legal representative or is duly authorized as the patient's general agent to execute the above and accepts its terms

SIGNATURE PATIENT	DATE	RELATIONSHIP IF NOT PATIENT