



CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license & insurance card.
 The information you supply is confidential. We comply with all federal privacy standards.

Please print clearly.

 Today's Date

Have you been treated by a chiropractor before? No Yes _____
 Satisfied with the treatment? No Yes _____ When

How did you hear about us? _____

Gender Male Female Social Security Number: _____ Left Handed
 Right Handed

 Patient's Last Name First Name Middle Name

 Address Patient's Birth Date

 City State Zip

Marital Status: Single Widowed
 Married Divorced
 Partner Separated

Anniversary Date: _____

 Home Phone

 Work Phone

 Cell Phone

 Email

 Emergency Contact Name

 Spouse's Name Birth Date

 Children's Names and Ages: _____

 Phone Relationship

Would you like to be put on the
 clinic's prayer list? Yes No

 Patient's Occupation

 Patient's Employer

 Patient's Employer's Address

Primary Insurance Plan:

 Insurance Carrier

 Insured's Name

 Insured's Employer

 Policy Number

 Insured's Birth Date

 Insured's Employer's Address

 Group Number

 Relationship

Secondary Insurance Plan: (Please note that we are happy to bill your Primary Insurance. Secondary Insurance is your responsibility.)

 Insurance Carrier

 Insured's Name

 Insured's Employer

 Policy Number

 Insured's Birth Date

 Insured's Employer's Address

 Group Number

 Relationship



CONFIDENTIAL HEALTH INFORMATION
REVIEW OF SYSTEMS

Patient's Name: _____

Today's Date: _____

Musculoskeletal

- | | | | |
|---|--|---|---|
| Had <input type="checkbox"/> Have <input type="checkbox"/> Osteoporosis | Had <input type="checkbox"/> Have <input type="checkbox"/> Neck Pain | Had <input type="checkbox"/> Have <input type="checkbox"/> Elbow/Wrist Pain | Had <input type="checkbox"/> Have <input type="checkbox"/> Muscle Spasms/Cramps |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Back Pain | <input type="checkbox"/> <input type="checkbox"/> Foot/Ankle Pain | <input type="checkbox"/> <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> <input type="checkbox"/> Scoliosis | <input type="checkbox"/> <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> <input type="checkbox"/> Hip / Knee Pain | <input type="checkbox"/> <input type="checkbox"/> Jaw Pain |

Neurological

- | | | | |
|--|---|---|---|
| Had <input type="checkbox"/> Have <input type="checkbox"/> Anxiety | Had <input type="checkbox"/> Have <input type="checkbox"/> Headache | Had <input type="checkbox"/> Have <input type="checkbox"/> Dizziness/Fainting | Had <input type="checkbox"/> Have <input type="checkbox"/> Numbness |
| <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Concussion | <input type="checkbox"/> <input type="checkbox"/> Pins & Needles | |

Cardiovascular

- | | | | |
|--|---|---|---|
| Had <input type="checkbox"/> Have <input type="checkbox"/> High Blood Pressure | Had <input type="checkbox"/> Have <input type="checkbox"/> High Cholesterol | Had <input type="checkbox"/> Have <input type="checkbox"/> Angina | Had <input type="checkbox"/> Have <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> <input type="checkbox"/> Stroke |

Respiratory

- | | | | |
|--|--|---|--|
| Had <input type="checkbox"/> Have <input type="checkbox"/> Asthma | Had <input type="checkbox"/> Have <input type="checkbox"/> Emphysema | Had <input type="checkbox"/> Have <input type="checkbox"/> Sinus Problems | Had <input type="checkbox"/> Have <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Hay Fever | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | |

Digestive

- | | | | |
|--|---|--|---|
| Had <input type="checkbox"/> Have <input type="checkbox"/> Eating Disorder | Had <input type="checkbox"/> Have <input type="checkbox"/> Food Sensitivities | Had <input type="checkbox"/> Have <input type="checkbox"/> Dairy Intolerance | Had <input type="checkbox"/> Have <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> <input type="checkbox"/> Ulcer | <input type="checkbox"/> <input type="checkbox"/> Gluten Intolerance | <input type="checkbox"/> <input type="checkbox"/> Nut Allergies | <input type="checkbox"/> <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> <input type="checkbox"/> Poor Appetite | | | |

Sensory

- | | | | |
|---|---|--|---|
| Had <input type="checkbox"/> Have <input type="checkbox"/> Blurred Vision | Had <input type="checkbox"/> Have <input type="checkbox"/> Hearing Loss | Had <input type="checkbox"/> Have <input type="checkbox"/> Loss of Taste | Had <input type="checkbox"/> Have <input type="checkbox"/> Loss of Feeling to Touch |
| <input type="checkbox"/> <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> <input type="checkbox"/> Chronic Ear Infect. | <input type="checkbox"/> <input type="checkbox"/> Loss of Smell | |

Integumentary (Skin)

- | | | |
|--|---|--|
| Had <input type="checkbox"/> Have <input type="checkbox"/> Skin Cancer | Had <input type="checkbox"/> Have <input type="checkbox"/> Eczema | Had <input type="checkbox"/> Have <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> <input type="checkbox"/> Psoriasis | <input type="checkbox"/> <input type="checkbox"/> Acne | <input type="checkbox"/> <input type="checkbox"/> Rash |

Endocrine

- | | | | |
|---|---|--|---|
| Had <input type="checkbox"/> Have <input type="checkbox"/> Thyroid Issues | Had <input type="checkbox"/> Have <input type="checkbox"/> Hypoglycemia | Had <input type="checkbox"/> Have <input type="checkbox"/> Frequent Infections | Had <input type="checkbox"/> Have <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> <input type="checkbox"/> Low Libido |

Genitourinary

- | | | | |
|--|---|--|---|
| Had <input type="checkbox"/> Have <input type="checkbox"/> Kidney Stones | Had <input type="checkbox"/> Have <input type="checkbox"/> Bedwetting | Had <input type="checkbox"/> Have <input type="checkbox"/> Prostate Issues | Had <input type="checkbox"/> Have <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> <input type="checkbox"/> PMS Symptoms |



ARCHER FAMILY WELLNESS CLINIC

Dr. Donna M. Archer
Chiropractic Physician

CONFIDENTIAL HEALTH INFORMATION

Patient's Name: _____

Today's Date: _____

ILLNESSES

Had <input type="checkbox"/>	Have <input type="checkbox"/>	AIDS or STD	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Cancer	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Glaucoma	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Measles / Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Polio

Had <input type="checkbox"/>	Have <input type="checkbox"/>	Rheumatic Fever	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

INJURIES

Have you ever.....

Had a broken bone

Had a spine or nerve injury

Been knocked unconscious

Been injured in an accident

SOCIAL HISTORY

	Daily	Weekly	Occasionally	How much?
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Caffeine Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain Relievers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

OPERATIONS

<input type="checkbox"/> Appendix Removal	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Neck Surgery
<input type="checkbox"/> Gallbladder Removal	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Back Surgery
<input type="checkbox"/> Bypass Surgery	<input type="checkbox"/> Knee Replacement	<input type="checkbox"/> _____
<input type="checkbox"/> Cancer Surgery	<input type="checkbox"/> Hip Replacement	<input type="checkbox"/> _____

FAMILY HISTORY

Relative	Age (if living)	State of Health		Illnesses	Age at Death	Cause of Death
		Good	Bad			
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sibling 1 M F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sibling 2 M F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sibling 3 M F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sibling 4 M F	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Mother's Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Mother's Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Father's Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Father's Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Are there any hereditary health issues that you know about? _____

MEDICATIONS and SUPPLEMENTS: (Use back of page if you need more room)



CONFIDENTIAL HEALTH INFORMATION

Patient's Name: _____

Today's Date: _____

ACTIVITIES OF DAILY LIVING

	NO Affect	Mild Affect	Moderate Affect	Severe Affect		NO Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grocery Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Showering / Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Love Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a Computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting to Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting In / Out of Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staying Asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking Over Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yard Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is the major stressors in your life? _____

Hour many hours sleep do you average? _____ Age of you Mattress: _____ Age of Pillow: _____

Describe your typical eating habits: Skip Breakfast 2 Meals a Day 3 Meals a Day Snacks

What would be the most significant thing that you could do to improve your health? _____

In addition to the main reason for your visit today, what additional health goals do you have? _____

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ AND ACCEPT THE FOLLOWING:

- u I instruct Dr. Archer to deliver the care that, in her professional judgment, can best help me in the restoration of my health.
- u I may request a copy of the PRIVACY POLICY & understand it describes how my personal health information is protected & released on my behalf for seeking reimbursement from any involved third parties.
- u I grant permission to be called to confirm or reschedule an appointment & to be sent occasional cards, letters, postcards, emails or health information as an extension of my care in this office.
- u I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
- u I acknowledge that there is a \$25.00 fee for missed appointments. We appreciate your calling to cancel or reschedule if you cannot keep your appointment. Please give 24 hours notice if you will not be able to keep your appointment (if possible).
- u To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or causes of my health concerns.
- u If the patient is a MINOR CHILD, print child's full name here:

Signature

Today's Date



Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Sign Name

Today's Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Print Name

Sign Name

Today's Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Print Name

Sign Name

Today's Date