HEALTH HISTORY

Today's Date _____

PERSONAL INFO

Name _____ Date of Birth _____ Gender _____
Address _____ City _____ State _____
Cell Phone _____ Other Phone _____
Email Address _____
Occupation _____ Employer _____
Marital Status _____ Spouse/ Partner's name _____
Names & Ages of Children _____
Emergency Contact _____ Emergency Phone _____
Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel All Bright Chiropractic can address for you?

_____
_____
_____

Are these concerns affecting your quality of life?

Work	□Y □N	Driving	□Y □N	Sleep	□Y □N
School	□Y □N	Walking	□Y □N	Sitting	□Y □N
Exercise/ Sports	□Y □N	Eating	□Y □N	Love life	□Y □N

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)
□Relief of a symptom or problem
□Relief and prevention of a symptom or problem
□Healthier spine and nerve system
□Optimal health on all levels

HEALTH CARE PRACTITIONER HISTORY

Have you ever received chiropractic care? □Y □N
Have you consulted or do you regularly consult any of the following providers?

□ Medical Doctor	□ Naturopath	□ Acupuncturist	□ Homeopath
□ Massage Therapist	□ Counselor	□ Energy Healer	□ Dentist

Reason:

_____
_____

HEALTH, VITALITY, & CHIROPRACTIC CARE

The primary system in the body which coordinates health is the **nerve system**. The vertebrae bones of the spinal column surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called **vertebral subluxation**. Vertebral subluxation results in nerve malfunction due to vertebral/ spinal misalignment. Spinal subluxations can have physical, emotions, and chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL, and CHEMICAL stressors you have been subjected to in your life and how they may be related to your present spinal nerve and health status and whether they may have caused vertebral subluxations to occur.

Physical Stress

- □ Birth Difficulty (as a Mother or Child)
- □ Serious Slips/ Falls
- □ Automobile Accidents
- □ Sports Injuries
- □ Physical Abuse
- □ Work Injuries
- □ Poor Posture
- □ Sitting on your Wallet
- □ Not Enough/ Poor Sleep
- □ Extensive Computer Work
- □ Carrying Heavy Purse/ Bookbag/ Child
- □ Repetitive Lifting/ Bending
- □ Spending Many Hours in a Car
- □ Hospitalization
- □ Bone Fracture
- □ Surgery

Emotional Stress

- □ Difficult Breakup/ Divorce
- □ High Stress Career
- □ High Family Stress
- □ Money
- □ Recurrent Illness
- □ Fast-Paced Life
- □ Hold in Feelings
- □ Quick-Tempered
- □ Verbal/ Emotional Abuse
- □ Perfectionist
- □ Body Image Issues
- □ Made Fun of/ Bullied
- □ Sickness or Loss of Loved One
- □ Difficulty Letting Go of Control
- □ Lifestyle Change
- □ Childhood Trauma

Chemical Stress

- □ Environment (i.e. Poor Air/ Water)
- □ Smoker/ Second Hand Smoke
- □ High Sugar Consumption
- □ Poor Diet
- □ Soda Pop
- □ Coffee
- □ Artificial Sweeteners
- □ Energy Drinks
- □ Vaccinations
- □ Prescription/ OTC Drugs (list below)
- □ Antibiotics
- □ Recreational Drugs
- □ Alcohol
- □ Work with Chemicals
- □ Poisoning
- □ Tobacco

Please list any prescription or over-the-counter medications you take _____

_____

Please list any supplements or vitamins you take _____

_____

How much water do you drink daily? _____

How much and what type of exercise do you get regularly? _____

Do you have allergies or sensitivities to any foods? □N □Y _____

FOR WOMEN

□ Currently pregnant	□ Breastfeeding	□ Birth control pills/ patch/ ring
□ Painful periods	□ Irregular cycles	□ Fatigue
□ Anxiety/ Depression	□ PMS	□ Weight Changes

QUALITY OF LIFE

How do you grade your physical health?	□ Good	□ Fair	□ Poor
How do you grade your emotional/ mental health?	□ Good	□ Fair	□ Poor
How do you rate your overall quality of life?	□ Good	□ Fair	□ Poor

FINANCES

Payment in full is expected on all FIRST VISIT services.

First Visit Fee: Comprehensive Exam $100 Adjustment (if appropriate): $50

Our Unique Approach to Finances at ABC

Our patients pay for care "out of pocket" because insurance plans DO NOT COVER corrective or wellness care. We utilize uniquely designed, discounted cash plans to allow you to receive all the care necessary (as determined by your chiropractic evaluation) at affordable fees. We will discuss our recommendations for care as well as assist you in finding the perfect care plan after you complete your New Patient consultation and exam.

Insurance

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will happily provide you with itemized monthly statements for you to submit.

The information I have provided on this case history form is true and accurate to the best of my knowledge. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon. I give Dr. Marqelle Albrecht permission to render care to me today.

Name (printed) _____ Date _____
Signature _____

CONSENT FORM

PLEASE READ AND SIGN

1. A copy of All Bright Chiropractic's Notice of Privacy Practices for Protected Health Information (HIPAA) is available for my review in the office.

2. I understand that care is given in an open setting. A private room may be available upon request but is not guaranteed.

3. I consent to receive communication from ABC in connection with my care via email, postal mail, text and telephone messaging. If I should withdraw my consent, I will notify the office in writing.

4. I consent to my testimonial being used in office and electronically with my first name and last initial only. If I should withdraw my consent, I will notify the office in writing.

5. I consent to my photo or image being used in photograph or video in public media including social media, website, and other promotional materials. If I should withdraw my consent, I will notify the office in writing.

6. I agree that I am responsible to pay for all services I receive in this office.

Name (printed) _____ Date _____
Signature _____

Please note below any withdrawal of consent to any of the above statements:

Signature _____ Date _____

Welcome to All Bright Chiropractic!

DR. MARQELLE ALBRECHT

701.297.8191 1121 WESTRAC DR. SUITE 102 FARGO, ND 58103