Adult Chiropractic Health Questionnaire

Name: ____ **Date**: ____________ **Birth Date**: ___________

Address: ____ **City**: _______________ **Zip**: ________________

Home Phone: ___________________ **Cell Phone**: _____________________ **Work Phone**: ________________

Occupation: ________________________________ **Employer**: ____

Email Address: ______________________________________ **Marital Status**: ___________________________

Spouse/Significant others Name: _______________________________ **No. of Children**: __________________

Which number would you prefer to be contacted at?

Home / Cell / Work Phone /Do not leave voice messages (please circle all that apply)

We always appreciate referrals! **Which helped you find our office today? Friend/Family Member/Website**

Name:___________________________________ Can we thank them? Y N

REASON FOR SEEKING CHIROPRACTOR CARE

What can we help you with?

Please List: ____

When did this begin? ____

What aspects of your life are these concerns affecting? ____

Has this happened before? Y N **Has anything helped? Y N**

If yes please explain: ____

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Y N **Name of D.C.:** _________________________________

Date of last visit: ____________________

FOR WOMEN

Are you pregnant? Y N Possible/Unknown

If pregnant what is your due date? __________________ **Name of OBGYN or Midwife:**_____________________

If x-rays are recommended, your signature is required to indicate that you are not pregnant.

Signature: ____ **Date:** _________________________________

TRAUMAS & PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

Have you had any **accidents, injuries, Hospitalizations, or surgeries in your life** related to any of the following? Accidents have an accumulation effect on the spine. (Check all that apply)

☐ Automobile ☐Motorcycle ☐ Bicycle ☐Sports ☐Playground ☐Abuse

If yes, state **type of injury and date:**

____

____

____

QUALITY OF LIFE

Do you **exercise** regularly? If yes, how often? ______________________________

Do you follow a **special dietary regime?** If yes, what is it? ______________________________

How would you rate the quality of your sleep? ☐Great ☐Moderate ☐Poor

On average, how much sleep do you get a night? ______________________________

What position do you sleep in? (Check all that apply) ☐Back ☐Side ☐Stomach

Do you take any vitamins or supplements: Y N

If yes, what are they and how often do you take them: ______________________________

Do you have any **allergies** to any foods? Y N **If yes, please list:** ______________________________

Do you presently **consume** any of the following?

☐Coffee/Caffeine ☐Alcohol ☐Tobacco ☐Over the counter drugs ☐Prescribed Drugs

Prescription Drugs are one of the leading causes of death in the US, please tell us what **Prescription Drugs** you are currently taking and **specifically what conditions or symptoms they were prescribed for:**

____

____

Note: It is imperative that you list all medications as they may have influence on your care.

Review of Systems:

Please place an "X" next to all that relate to your health.

Constitutional Gastrointestinal Hematologic

Constitutional	Gastrointestinal	Hematologic
( )Weight Loss	( )Abdominal Pain	( )Easy Bruising
( )Fever	( )Nausea/Bloating	( )Gums Bleed Easily
( )Fatigue	( )Heartburn	( )Enlarged Glands
( )Appetite Change	( )Rectal Bleeding	( )Blood in Stool
( )Diarrhea	( )Constipation	

Ear/Nose/Throat/Musculoskeletal

( )Vertigo
( )Joint Pain/Swelling
( )Frequent Sore throat
( )Hoarseness
( )Ear Infections
( )Stiffness
( )Muscle pain
( )Frequent Nose Bleeds
( )Unexplained Weakness
( )Back Pain

Cardiovascular

( )Palpitations
( )Swelling of extremities
( )High Blood Pressure
( )Chest pain
( )Racing pulse

Genitourinary

( )Painful Urination
( )Blood in urine
( )Burning
( )Trouble Voiding
( )Racing pulse

Neurologic

( )Stroke
( )Vision Disturbance
( )Migraines
( )Depression
( )Loss of Consciousness
( )Seizures
( )Headaches
( )Numbness
( )Memory Loss
( )Anxiety

Respiratory/Skin

( )Shortness of breath
( )Coughing Blood
( )Wheezing
( )Persistent cough
( )Frequent infections
( )Rash/Sores
( )Lesion
( )Itching
( )Eczema
( )Psoriasis

PATIENT NAME: ______________________________ DATE: ________________

Dawson Chiropractic: A Creating Wellness Center

Please number each activity below according to the following ratings:

0 = No affect

1 = I am aware of my problem when I do this activity (Mild)

2 = I don't want to do this activity because of my problem (Moderate)

3 = I can't do this activity at all (Severe)

HOUSEWORK

___ Doing laundry
___Making Beds
___ Vacuuming
___ Washing dishes
___ Ironing
___Carrying groceries
___ Caring for pets
___ Cooking

YARD WORK

___ Mowing lawn
___ Shoveling Snow
___ Raking leaves
___ Gardening

GENERAL

___ Walking
___ Standing
___ Running
___ Sitting
___ Lifting children
___ Bending
___ Climbing stairs
___ Reading
___ Laying in bed
___ Chewing

PERSONAL GROOMING

___ Combing hair
___ Shaving
___ In/out bathtub
___ Brushing teeth

TRAVEL

___ Driving
___ Riding (Passenger)
___ Getting in and out of auto

OTHER

___ Playing piano
___ Using typewriter/computer
___ Kneeling
___ Sexual Intercourse
___ Exercising
___ Swimming
___ Sleeping
___ Using telephone
___ Sitting in recliner
___ Sports- List:
____

OTHER: Please list any other difficulties you are experiencing with activities you have engage in since your condition arose ____

____

Signature: ____________________________ **Date:** _________________

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest.

By signing below, I agree to the above and allow the doctor, affiliated with Dawson Chiropractic, to perform such. This consent will cover the entire course of my treatment.

Patient Name: ____ ***Date:*** _______________

Patient or Guardian Signature: ____________________________ ***Date:*** ________________

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor 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 at this office.*

SIGN IF READ ABOVE ____**DATE**_________________

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information 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 that, 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 have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Name (please print):____**Relationship to patient:**________________________

Signature:____**Date:**________________________

Would you like a copy of the HIPPA privacy notice Yes ☐ No ☐

X-RAY CONSENT FORM

Patient: ________________________________ Date: _________________

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please choose one:

________ I understand that my doctor may need x-rays in order to diagnosis my condition and I **give** permission of all needed diagnostic tests.

________ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. **I choose not to have any x-ray at this time and release my doctor of all liabilities.**

Signature: ________________________________ Date: __________________

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam.

With those factors in mind, I am advising my doctor that:

I am pregnant ______ yes ______ no ______ don’t know

I could be pregnant ______ yes ______ no ______ don’t know

My menstrual period is late ______ yes ______ no _______ don’t know

I have an IUD ______ yes ______ no

I have had a tubal ligation ______ yes ______ no

I have had a hysterectomy ______ yes _______ no

I have irregular menstrual periods ______ yes _______ no

My last menstrual period began _____________________

I have begun menopause ______ yes _______ no

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: ________________________________ Date: ___________________