



Adult Chiropractic Health Questionnaire

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.



Name _____ Home Phone _____
Address _____ Work Phone _____
City, State, Zip _____ E-mail Address _____
Birth date _____ Age _____ SS# _____
Marital Status: M W Sep. D Single Spouse Name _____ No. of Children _____

How payment will be made: Cash Check- Credit Card-
Type of Insurance Health Automobile Worker's Comp
Please give your card to the receptionist to be copied.

- Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name _____
 Telephone Call Yellow Pages Sign Website Presentation E-mail
- Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ Never
- When was your last complete spinal examination including x-rays? _____ Never
- Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? YES NO _____
- Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? YES NO
- Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? YES NO
- Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent
- Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High
- Please list any health symptoms or health complaints you are experiencing.
1. _____ 2. _____ 3. _____
- Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

- Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury? YES NO Date of Incident _____
- Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? YES NO
- Have you ever been diagnosed with cancer? Type _____ Year _____
- How much do you spend on vitamins/supplements each month?
(approx) _____
- Would you like to receive our weekly health and wellness newsletter via e-mail?
 YES NO

The above information is true and accurate to the best of my knowledge. _____ Initial

MY PURPOSE

FOR TODAY'S APPOINTMENT IS: (PLEASE CHECK ALL THAT APPLY)

- ___ I'm here for an evaluation. I'm a healthy person & I'm interested in maximizing my health & preventing future problems.
- ___ I'm here for an evaluation because I'm having health challenges & am looking for a natural health solution.
- ___ I'm here for an evaluation. I am curious to know if my spine is healthy & to see if I have any problems I'm unaware of.
- ___ I am here for an evaluation because I'm curious to learn more about Chiropractic Care.
- ___ I am here for an evaluation only.
- ___ Other _____

IF THE DOCTOR FEELS HE CAN HELP YOU: (PLEASE CHECK ALL THAT APPLY)

- ___ I am willing to follow the doctor's recommendations because I strongly value my health.
- ___ I am willing to receive care if payment plans are available.
- ___ I am willing to receive care but only if my insurance pays for all of it.
- ___ I am not interested in receiving any care.

Health History:

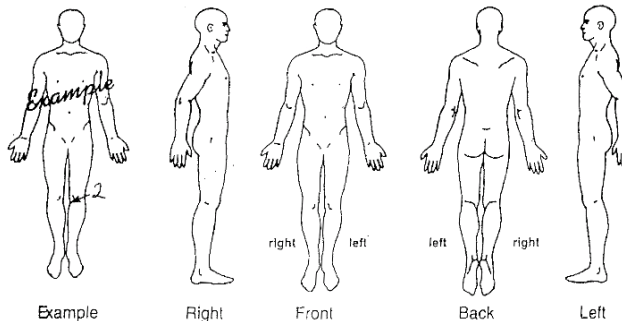
Please check all of the following health concerns that you have experienced in the past, even if you do not think that your answers relate to your present health concern.

- | | | | |
|-------------------------------|------------------------------|------------------------|------------------------------|
| Allergies | <input type="checkbox"/> Yes | Heart Condition | <input type="checkbox"/> Yes |
| Anxiety | <input type="checkbox"/> Yes | Immune System Disorder | <input type="checkbox"/> Yes |
| Arthritis | <input type="checkbox"/> Yes | Infertility | <input type="checkbox"/> Yes |
| Asthma | <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> Yes |
| Back Pain | <input type="checkbox"/> Yes | Menstrual Cramps | <input type="checkbox"/> Yes |
| Bladder Problems | <input type="checkbox"/> Yes | Mood Swings | <input type="checkbox"/> Yes |
| Cancer | <input type="checkbox"/> Yes | Neck Pain | <input type="checkbox"/> Yes |
| Circulatory/Vascular Disorder | <input type="checkbox"/> Yes | Numbness/Tingling | <input type="checkbox"/> Yes |
| Colds/Flu | <input type="checkbox"/> Yes | Osteoporosis | <input type="checkbox"/> Yes |
| Depression | <input type="checkbox"/> Yes | Sinus Trouble | <input type="checkbox"/> Yes |
| Diarrhea | <input type="checkbox"/> Yes | Skin Conditions | <input type="checkbox"/> Yes |
| Digestive Problems | <input type="checkbox"/> Yes | Urinary Difficulty | <input type="checkbox"/> Yes |
| Dizziness | <input type="checkbox"/> Yes | Vertigo | <input type="checkbox"/> Yes |
| Headaches | <input type="checkbox"/> Yes | Other: _____ | <input type="checkbox"/> Yes |
| Heartburn/Reflux | <input type="checkbox"/> Yes | | |

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off and on, when standing, when sitting, etc.

COMPLETE THESE DIAGRAMS

Cervical – 1 2 3 4 5 6 7 8 9 10 Mid-Back – 1 2 3 4 5 6 7 8 9 10 Lower Back – 1 2 3 4 5 6 7 8 9 10
SEVERITY OF PAIN (circle one) -- with 1 being the least and 10 the most



The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Fees are payable at time of service unless arrangements are made in advance. X-rays remain the property of this clinic.

NO GUARANTEE OF RESULTS

Participation in this chiropractic program is not a guarantee to prevent or cure any disease or medical condition. Any balance due for services are due regardless of results.

Patient Signature _____

Date _____