Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name: Last Name: Date:

SS#: DOB: Sex: M F

Marital Status: # of Children: Occupation:

Street Address: Height: ft. in.

City: State: Zip: Weight: lbs.

Email: Cell Phone: Other Phone:

Emergency Contact: Emergency Relation: Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? Yes No

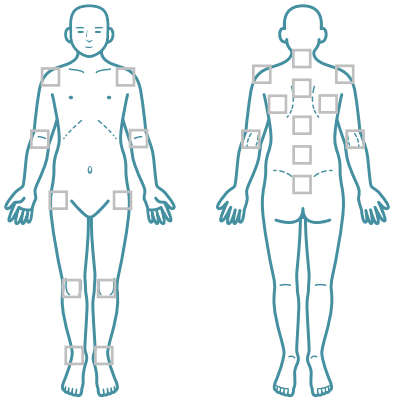
- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.



Have you received care for this problem before? Yes No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? Suddenly Gradually Post-Injury

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. _____

2. _____

3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ Overall wellness ◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ◯ Yes ◯ No
- If yes, please explain:

Notable childhood injuries? ◯ Yes ◯ No If yes, please explain:

Youth or college sports? ◯ Yes ◯ No If yes, list major injuries:

Any auto accidents? ◯ Yes ◯ No If yes, please explain:

Exercise Frequency? ◯ None ◯ 1-2x per week ◯ 3-5x per week ◯ Daily
What types of exercise?

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach Do you wake up: ◯ Refreshed and ready ◯ Stiff and tired

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ Date: _____

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Pregnancy Questionnaire

Patient Name: _____ Date: _____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ◯ Yes ◯ No

- If not, please tell us about your previous pregnancy and/or birth experience(s).

Do you plan to follow the same plan as your previous delivery? ◯ Yes ◯ No

- If no, what would you like to change?

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date?

Did you have any difficulty conceiving? ◯ Yes ◯ No

- If yes, please explain:

Have you ever used any form of hormonal or oral contraceptives? ◯ Yes ◯ No

- If yes, which ones, and for how long?

When was your last menstrual cycle?

What was your pre-pregnancy weight? lbs. Current weight? lbs.

Have you experienced morning sickness? ◯ Yes ◯ No

- If yes, please explain:

CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently performing?

Please tell us about your current diet, and any dietary restrictions.

Have you taken any medications or supplements during your pregnancy? ◯ Yes ◯ No

- If yes, please explain:

Have you had any slips, falls, or other physical traumas during the pregnancy? ◯ Yes ◯ No

- If yes, please explain:

Have you had any major emotional stressors during your pregnancy? ◯ Yes ◯ No

- If yes, please explain:

YOUR BIRTH PLAN

Your top three goals for this pregnancy:

1. _____
2. _____
3. _____

Do you currently have a birth plan? ◯ Yes ◯ No

- If yes, please explain:

Are you taking any pre-natal or birthing classes? ◯ Yes ◯ No

- If yes, please explain:

Who is your OB/GYN or midwife? Will they be present for delivery? ◯ Yes ◯ No

Who is your birth provider?

Do you intend to have a doula or birth coach present? ◯ Yes ◯ No

- If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? ◯ Yes ◯ No

- If not, what concerns do you have?

YOUR POST-BIRTH PLAN

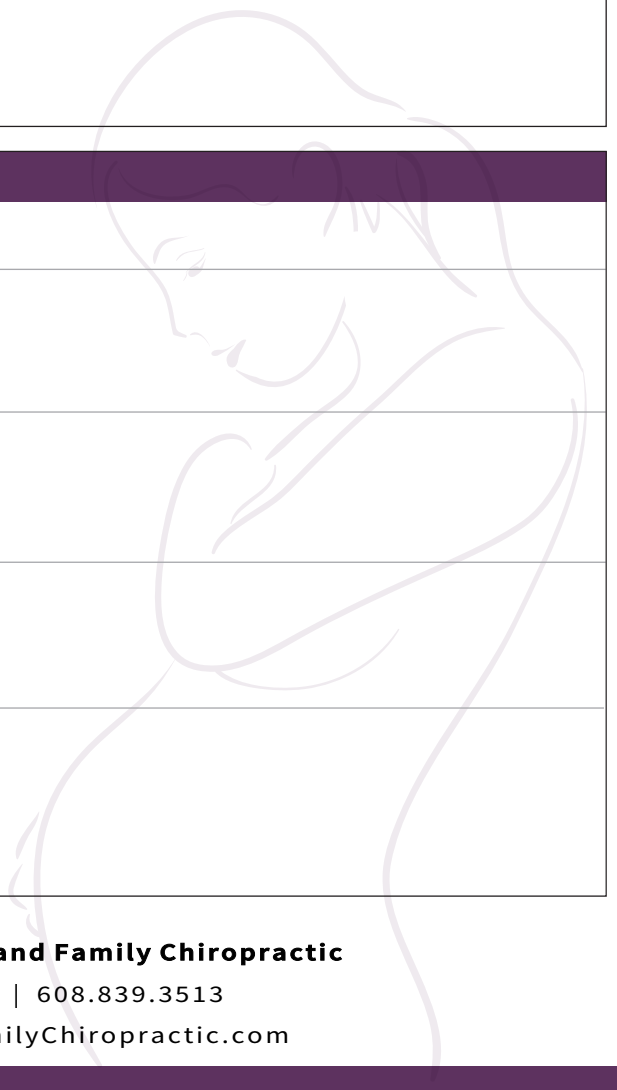
Do you plan on breastfeeding your child? ◯ Yes ◯ No

What do you intend to do for vaccines?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

What would you like to gain from chiropractic care during your pregnancy?

Are there any burning questions you want to be sure to ask today?



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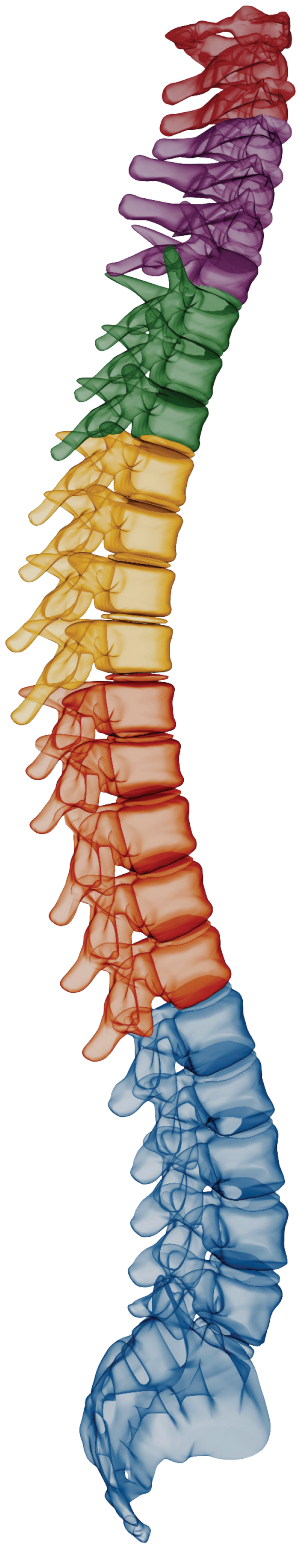
Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Chrohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name: _____ Date: _____

Struggle Survey

Tell us about your struggles, whether they be pain related (headaches, back pain, neck pain, wrist/ankle pain, etc.) or functional (digestion, energy, ADD/ADHD, vertigo, sleep, etc.) you have been experiencing.

If you are truly here for wellness and haven't had any struggles in the last month please check this box. ☐

Struggle 1: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) Progression: ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe Frequency: ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture Helpful? ◯Yes ◯No

Struggle 2: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) Progression: ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe Frequency: ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying ☐stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture Helpful? ◯Yes ◯No

Struggle 3: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) Progression: ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe Frequency: ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying ☐stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture Helpful? ◯Yes ◯No

**For additional struggles, please fill out another "Struggle Survey" form to submit or write on the back of this page.

Contact Information Changes

If any of your contact information has changed please provide the new information below.

Address: _____

Phone Number: _____ E-mail Address: _____

Contact Preference: ◯Phone ◯E-mail ◯Text Form delivery: ◯E-mail ◯Mail ◯In person

Any changes to your insurance information? ◯Yes ◯No If yes, please supply us with your new insurance card.

Terms of Acceptance

The goal of our office is to enable patient to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions please feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from a latent pathological defect, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a chiropractor at Heartland Family chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment, will be explained to me upon my request. It is understood and agreed that the amount paid to the doctor for x-rays are for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependents behalf in full or according to insured contractual agreement. I authorize the chiropractor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

ACKNOWLEDGMENT

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

COMMUNICATION

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes No

MISSED APPOINTMENTS

There is a possible $25 fee charged for all appointments that are not cancelled prior to scheduled visit.

I, _____, have read and fully understand the above statements. I hereby attest that the information and health history I have provided is complete and accurate. I understand the importance of providing a truthful health history in order to assist the doctor in providing the best chiropractic care possible.

Print Name:_____

Signature:_____Date:_____

CONSENT TO TREAT A MINOR

Parent Signature:_____Date:_____