

Adult Health Questionnaire (Ages 13+)

Name _____ Date _____ Birthdate _____

Address _____
Residence and mailing City State Zip Code

Home Phone (_____) _____ Cell Phone (_____) _____

E-mail address _____ @ _____ Male Female

Occupation _____ Single ___ Married ___ Divorced ___ Widowed ___

Spouse's Name _____ Children (name, age) _____

Who may we thank for referring you to our office? _____

HEALTH HISTORY

Reason for seeking care in our office _____

Are you under the care of any other doctor? (Medical, Chiropractic, or Other) Yes No

If Yes, the conditions being treated for: _____

List any current medications _____

List any current supplements _____

List any past surgeries and dates _____

List any past accidents and dates _____

List any injuries you've had _____

Have you ever been under chiropractic maintenance care? Yes No

POTENTIAL CAUSES OF SUBLUXATIONS

Please check (X) any stresses you have encountered since your last adjustment (or in your lifetime if you have never been adjusted).

PHYSICAL

- Slip or fall
- Sporting activity
- Lifting
- Prolonged computer/TV time
- Sleeping in a weird position
- Manual labor
- Housework
- Pregnancy
- Being born
- (other) _____

MENTAL

- Work
- Rush-hour traffic
- Taxes
- Bills
- Arguments
- Deadlines
- Busy schedules
- Homework
- Exams
- (other) _____

CHEMICAL

- Medications (OTC or prescription)
- Nicotine
- Alcohol
- Soda (regular or diet)
- Fast food
- Microwavable meals
- Energy drinks
- Sugar
- Vaccines / Immunizations
- (other) _____

HEALTH INVENTORY

If you have experienced any of the following, please indicate by writing C (Current), P (Past), or C,P (Current and Past).

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck pain / stiffness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Lights bother eyes |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tension | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Menstrual pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Leg/foot pain | <input type="checkbox"/> Arm/hand pain | <input type="checkbox"/> Brain Fog |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Difficulty focusing |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Unexplained weight loss/gain |

Comments _____



Disease/
Sickness

Symptoms/
PAIN

Asymptomatic/
NO PAIN

100% Alive
Healthy

*Please put a **X** where you are currently. Please put an **O** where you would like to be.*

FAMILY HISTORY

	Cancer	Heart Disease	Arthritis	Diabetes
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments _____

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.

Signature

Date

FOR DOCTOR'S USE ONLY



1777 Bunker Lake Blvd NW
Andover, MN 55304
763-413-6934

Informed Consent for Chiropractic Care

When a person seeks chiropractic health care and we accept him or her as a patient, it is essential for both to be working toward the same objective. It is important that each member understand both the objective and the method that will be used to attain this objective. 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 vertebra 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.

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

Signature

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.

Signature

Date



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HIPAA: Consent for Use and Disclosure of Health Information

In compliance with federal law, a copy of the national Standards for Privacy of Individually Identifiable Health Information is available upon request. The Privacy Notice describes in detail how a member's health information is used and shared with others.

All reasonable efforts will be made to protect the privacy of a member's health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example by e-mail or facsimile mail.

A copy of the Privacy Notice has been made available to me.

Name (print) _____ Date _____

Signature _____ Date of Birth _____

When member is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Signature of Representative _____ Date _____

Print Name _____ Relationship to Member _____