

## 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: \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

Rate the severity of your symptoms (circle):                      0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

How have your symptoms changed since they began (no change, gotten worse, comes and goes, etc.)?  
 \_\_\_\_\_

Things that aggravate my symptoms: \_\_\_\_\_

Things that relieve my symptoms: \_\_\_\_\_

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 and /or supplements: \_\_\_\_\_

List any past surgeries and dates: \_\_\_\_\_

List any past accidents/traumas and dates: \_\_\_\_\_

Have you ever been under chiropractic maintenance care?    Yes     No

### Family History

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

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### For Doctor's Use Only

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## 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.*

## 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).

- | <b>PHYSICAL</b>                                       | <b>MENTAL</b>                              | <b>CHEMICAL</b>  |
|---|--|--|
| <input type="checkbox"/> Slip or fall                 | <input type="checkbox"/> Work              | <input type="checkbox"/> Medications (OTC or prescription) |
| <input type="checkbox"/> Sporting activity            | <input type="checkbox"/> Rush-hour traffic | <input type="checkbox"/> Nicotine                          |
| <input type="checkbox"/> Lifting                      | <input type="checkbox"/> Taxes             | <input type="checkbox"/> Alcohol                           |
| <input type="checkbox"/> Prolonged computer/TV time   | <input type="checkbox"/> Bills             | <input type="checkbox"/> Soda (regular or diet)            |
| <input type="checkbox"/> Sleeping in a weird position | <input type="checkbox"/> Arguments         | <input type="checkbox"/> Fast food                         |
| <input type="checkbox"/> Manual labor                 | <input type="checkbox"/> Deadlines         | <input type="checkbox"/> Microwavable meals                |
| <input type="checkbox"/> Housework                    | <input type="checkbox"/> Busy schedules    | <input type="checkbox"/> Energy drinks                     |
| <input type="checkbox"/> Pregnancy                    | <input type="checkbox"/> Homework          | <input type="checkbox"/> Sugar                             |
| <input type="checkbox"/> Being born                   | <input type="checkbox"/> Exams             | <input type="checkbox"/> Vaccines / Immunizations          |
| (other) _____   | (other) _____                              | (other) _____  |

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



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\_\_\_\_\_