Essentials of Life Chiropractic

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 the 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
Children	☐	☐	☐	☐
Siblings	☐	☐	☐	☐
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐

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).**

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

PHYSICAL	***MENTAL***	***CHEMICAL***
____Slip or fall	____Work	____Medications (OTC or prescription)
____Sporting activity	____Rush-hour traffic	____Nicotine
____Lifting	____Taxes	____Alcohol
____Prolonged computer/TV time	____Bills	____Soda (regular or diet)
____Sleeping in a weird position	____Arguments	____Fast food
____Manual labor	____Deadlines	____Microwavable meals
____Housework	____Busy schedules	____Energy drinks
____Pregnancy	____Homework	____Sugar
____Being born	____Exams	____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

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1777 Bunker Lake Blvd NW#200
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_____