WALLACE FAMILY CHIROPRACTIC

ADULT CHIROPRACTIC HEALTH QUESTIONAIRE

Name _____ Home Phone _____

Address _____ Work Phone _____

City/State/Zip _____ Cell Phone _____

E-mail Address _____ Cell Provider _____

DOB _____ Age _____ SS# _____

Occupation _____ Employer _____

Marital Status _____ Spouse's Name _____ # of Children _____

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

1. Spinal problems can cause a variety of health problems. Please circle the health complaint(s) you are currently experiencing or experience on a periodic basis:

Neck Pain	Knee Pain L or R	Digestive Issues	Chronic Fatigue
Upper/Mid Back Pain	Arm or Hand Numbness/Tingling	Asthma	Arthritis
Shoulder Pain	Carpal Tunnel Syndrome	Allergies/Sinus	Fibromyalgia
Low Back Pain	Leg or Foot Numbness/Tingling	Acid Reflux	Frequent Colds
	Hip Pain L or R	Headaches	

Other _____

2. Is this visit related to an auto or work injury? YES NO _____
3. When was your last chiropractic examination including x-rays? _____
4. Have you ever been told that you have spinal curvature (AKA Scoliosis), spinal arthritis or inherited spinal problems? YES NO
5. Long term spinal misalignments can cause decay and arthritis in the spine which may result in grinding or popping noises. Do you ever hear grinding or popping noises when you move your head or neck? YES NO
6. Spinal misalignments can make you feel that you need to twist/stretch or crack your neck or back. Do you ever feel the need to twist, stretch, or crack your neck, mid or lower back?

   YES NO
7. Stress can cause or aggravate spinal problems. Please rate your stress level over the past 90 days.

   Low 1 2 3 4 5 6 7 8 9 10 High
8. Are you currently on any prescription or over the counter medications? YES NO If yes, please list:

_____

_____

9. Have you ever had a spinal surgery? YES NO If yes, please explain: _____

_____

10. Have you ever been diagnosed with cancer? YES NO If yes, what kind and year diagnosed:

_____

11. Spinal health is especially important during pregnancy. Is there any chance you are pregnant?

YES Due Date: _____ NO MAYBE

12. If Dr. Diann feels that you will benefit from chiropractic care, are you willing to follow her recommendations?

- ☐ I am willing to follow Dr. Diann'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 chiropractic care at this time.

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

Patient Signature: _____ Date: _____

Patient Name (Please Print): _____

WALLACE FAMILY CHIROPRACTIC
HEALTH HISTORY

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE
- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GENITO-Urinary
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

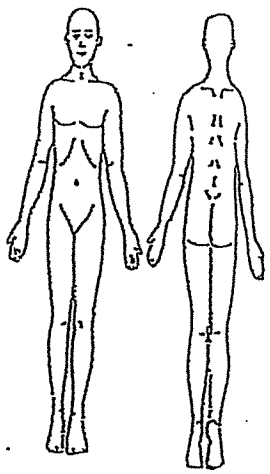
NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting/Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GASTRO-INTESTINAL
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Cramps
- ☐ Bloating
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

MALE/FEMALE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

_____
_____
_____

FEMALES ONLY
Are you pregnant?
☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY
The following members have a same or similar problem as I do:

- ☐ Mother _____
- ☐ Father _____
- ☐ Brother _____
- ☐ Sister _____
- ☐ Child _____

_____
_____
_____

Wallace Family Chiropractic

AUTHORIZATION FOR CHIROPRACTIC CARE

DATE: _____

I, the undersigned, a patient in this office hereby authorize Dr. Diann Wallace and whomever she may designate as her assistant to administer such examination/care as is necessary, and to perform the following therapy or procedures are as considered necessary on the basis of findings during the said course of examination/care.

I hereby certify that I have read and fully understand the above authorization for chiropractic examination/care, the reasons why the above named examination/care is considered necessary, its advantages and possible complaints, if any, as well as possible alternative modes of examination/care, which were explained to me by Dr. Diann Wallace.

I also certify that no guarantee of assurance has been made as to the results that may be obtained.

SIGNED: _____

Print Name: _____

Wallace Family Chiropractic
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Mount Laurel, NJ 08054
Phone: (856)-494-6789
Fax: (856)-494-6777
Tax ID: 82-5359753

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that Provides a more complete description of information uses and disclosures.
I understand that I have the following right and privileges:

. The right to review the notice prior to signing this consent.
. The right to object to the use of my health information for directory purposes.
. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or Health care operations.

____ I give my permission to Wallace Family Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, holiday cards, newsletters and information about treatment alternatives or other health related information. I also give permission to put my child's picture up on our "Chiro Kids Corner Wall"

_____ _____
PATIENTS SIGNATURE DATE

_____
PRINT NAME