** New Patient Health Questionnaire**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_State: \_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_**

 **Home Phone: \_\_\_\_\_\_\_Cell phone:\_\_\_\_\_\_\_\_\_\_\_Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth\_\_\_ /\_\_ /\_\_ Age: \_\_\_\_\_\_ Male/Female**

**SS#: \_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status:** M W D S **Spouse Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No # of Children \_\_\_\_\_\_\_\_\_\_\_**

**Name of Children \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Many patients are referred to our office by a family member or friend**. What or who made you decide to visit our office?**

***Science tells us your spine like your teeth need to be cared for regularly.***

1. **How often do you get adjusted by a chiropractor?** Frequently/Only when you hurt/1 x month/Never
2. **When was your last complete spinal examination including x-rays? \_ \_\_\_\_\_\_\_\_\_** Never \_\_\_\_\_
3. **Do you know if you have a Spinal curve\_\_\_\_Spinal Arthritis\_\_\_\_or Inherited spinal problem?\_\_\_\_\_**
4. Over time, spinal misalignments will cause arthritis and degeneration which may result in grinding or cracking to be heard when you move your neck or back, as well as loss of nerve health**. Do you hear these sounds when you move your head or neck?**  \_\_\_Yes \_\_\_No
5. If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. **Do you often feel the need to crack or pop your neck or lower back?**

\_\_\_Yes \_\_\_ No

1. Poor posture leads to poor health and early death. **How would you rate your posture?**

**Poor** 1 2 3 4 5 6 7 8 9 10  **Excellent**

1. Stress causes your spine to misalign and accelerates spinal damage. **Rate your stress level over the last 3 months.**

 **None** 1 2 3 4 5 6 7 8 9 10 **Intense**

1. **Please circle or list any health symptoms or health complaints you are experiencing.**

|  |  |  |  |
| --- | --- | --- | --- |
| Neck Pain L/R | Leg Pain L/R | Heart Disease | Thyroid |
| Midback Pain L/R | Asthma | Cancer | Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Low back Pain | Headaches/Migraines | Constipation  | Diabetes I / II |
| Arm Pain L/R  | Numbness/Tingling L/R | Menstrual Pain | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**10.** Prescription medications may cause various side effects and hide the severity of health problems while hindering the body's ability to heal. **What medications are you currently taking?**

 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**11. Please list any surgeries you have had, also include dates.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Do you smoke cigarettes?** \_\_\_Yes \_\_\_No  **Drink Alcohol?** \_\_\_Yes \_\_\_No **Times a week:\_\_\_\_\_\_**

**13. Spinal health is vitally important to ensure you and your baby are healthy. Is there a chance you are pregnant? \_\_\_\_** Yes **\_\_\_\_**No

1. **Daily trauma, auto accident(s), and work injuries can cause misalignment of vertebrae and serious spinal problems.**

When was your most recent injury at home?\_\_\_\_\_\_\_\_\_Car accident?\_\_\_\_\_\_\_\_\_\_\_Slip or fall?\_\_\_\_\_\_\_\_\_\_\_\_

1. Improper sleeping positions can cause spinal misalignment and spinal damage. **What sleeping position do you normally sleep in?**

\_\_\_ Back \_\_\_ Stomach \_\_\_ R Side \_\_\_ L Side

1. **Exercise level:** Never 1 2 3 4 5 6 7 8 9 10Often (at least 4-5 days a week)
2. **Are you ? \_\_\_** Right Handed  **\_\_\_** Left Handed
3. **Please list vitamins/supplements you take:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **If the doctor identifies your spine to be misaligned or subluxated, are you committed to follow the recommendations to correct your problem completely?**

 **\_\_\_**Yes \_\_\_ No

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

**Patient Signature (Parent/Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



CONSENT FOR TREATMENT OF MINOR

Date:\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Harrah Family Chiropractic and whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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.

Printed name of parent or legal guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent or legal guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Agreement**

I understand I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company. I understand this office will require payment from me for any services not covered by my health insurance plan. I hereby authorize my insurance benefits to be paid directly to Dr. Tyler Haderer or Harrah Family Chiropractic. I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

**Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient/Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Informed Consent for Chiropractic Care**

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

All questions regarding the doctor's objective to my care in this office has 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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.

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates/staff have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

**Date of last menstrual cycle:** \_\_\_\_\_\_\_\_\_\_\_

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**