Billing
CHIROPRACTIC
HEALTH + WELLNESS

Adult Patient Questionnaire

Confidential Patient Information

First Name:	Last Name:	Date:
SS #	Birthdate:	Sex: ___M ___F
Marital Status:	# of Children:	Occupation:
Street Address:		Height:
City, State, Zip:		Weight:
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Relationship:	Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you receiving care from any other health professional? ___Yes ___No
If yes, please name them and their specialty:

Please note any significant family medical history (surgeries, hip or knee replacements, pacemaker, etc.):

Current Health Conditions

What health conditions bring you to our office?

Have you received care for this problem before? ___Yes ___No
If yes, please explain:

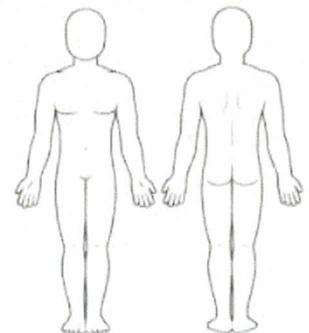
When did the condition(s) first begin?

How did the problem start? ___Suddenly ___Gradually ___Post-Injury

Is this condition: ___Getting worse ___Improving ___Intermittent ___Constant ___Unsure

What makes the problem better?

What makes the problem worse?



Your Health Goals (Please list your top 3 health goals)

1.

2.

3.

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CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ___Resolve existing condition(s) ___Overall wellness ___Both

Have you ever visited a chiropractor? ___Yes ___No If yes, what is their name?

Any spinal x-rays, CT, MRI taken in the last year? ___Yes ___No If so, where?

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries, or other injuries as an adult? ___Yes ___No
If yes, please explain:

Notable childhhod injuries? ___Yes ___No If yes, please explain:

Youth or college sports? ___Yes ___No If yes, list major injuries:

Any auto accidents? ___Yes ___No If yes, list major injuries:

Exercise Frequency? ___None ___1-2x per week ___3-5x per week ___Daily

What type of exercise?

How do you normally sleep? ___Back ___Side ___Stomach ___Do you wake up ___Refreshed & Ready ___Stiff & Tired

List any problems with flexibility (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		Moderate		High		None		Moderate		High
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs/other that you are taking and why:

ACKNOWLEDGEMENT & CONSENT

Patient Name: ______________________________ Date: ______________

Patient Name: ______________________________ **Date**: _________________________

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor or chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Billing Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _________________________ being the parent or legal guardian of _________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communication:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: ____________________________________

Children: ____________________________________

Others: ____________________________________

No one: _______

May we leave messages regarding your personal healthcare information on the answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ____

Signature: _____________________________________ Date: _____________________