About the Patient

Name _____

Date of Birth (month/day/year) _____/_____/_____ Age_____ Gender: M / F

Marital Status: ○ Married ○ Life Partners ○ Single ○ Divorced ○ Widowed

Address_____

City_____ State_____ Zip_____

Primary Phone (_____)_____-_____ Secondary/Work Phone (_____)_____-_____

Type of Work/Student _____Employer/School_____

Email:_____@_____._____

Referred by:_____

About the Spouse or Parent

Name_____

Address_____

City_____ State_____ Zip_____

Phone Number (_____)_____-_____

Relationship_____

Emergency Contact

Name_____

Address_____

City_____ State_____ Zip_____

Phone Number (_____)_____-_____

Relationship_____

Experience With Chiropractic

Have you been adjusted by a chiropractor before? (circle one) Yes No

Reason For Visit?_____

Doctor's Name_____ Approximate Date of Last Visit_____

Chief Complaints

Where is your injury/pain located?_____

Intensity of pain (circle 1 being least, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Onset of this episode? (day/month/year) _____/_____/_____

Frequency of pain? (circle one) 0%-25% 25%-50% 50%-75% 75%-100% Of the (circle one) Day Week Month

When does it hurt the most? (circle one) Morning Afternoon Evening Night

Does the pain shift or radiate from original location?_____

What is the quality of pain? (Check each box that applies)

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	Stiffness

What are the aggravating factors? (Check each box that applies)

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking up	Looking down	Movement	Rest	Lying supine	Driving
Typing	Scooping	House chores	Exercise	Lying prone	Stair stepping

What, if anything , relieves some of the pain? (Check each box that applies)

Sitting	Standing	Lying	Knees bent up	Support
No movement	Movement	Heat	Ice	Analgesic topical
Ibuprofen	Medication	Rest	Stretching/exercise	Adjustments

Second Complaint

Where is your injury/pain located?_____

Intensity of pain (circle 1 being least, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Onset of this episode? (day/month/year) _____/_____/_____

Frequency of pain? (circle one) 0%-25% 25%-50% 50%-75% 75%-100% Of the (circle one) Day Week Month

When does it hurt the most? (circle one) Morning Afternoon Evening Night

Does the pain shift or radiate from original location?_____

What is the quality of pain? (Circle each box that applies)

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	Stiffness

What are the aggravating factors? (Circle each box that applies)

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking up	Looking down	Movement	Rest	Lying supine	Driving
Typing	Scooping	House chores	Exercise	Lying prone	Stair stepping

What, if anything, relieves some of the pain? (Circle each box that applies)

Sitting	Standing	Lying	Knees bent up	Support
No movement	Movement	Heat	Ice	Analgesic topical
Ibuprofen	Medication	Rest	Stretching/exercise	Adjustments

Third Complaint

Where is your injury/pain located?_____

Intensity of pain (circle 1 being least, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Onset of this episode? (day/month/year) _____/_____/_____

Frequency of pain? (circle one) 0%-25% 25%-50% 50%-75% 75%-100% Of the (circle one) Day Week Month

When does it hurt the most? (circle one) Morning Afternoon Evening Night

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	Stiffness

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking up	Looking down	Movement	Rest	Lying supine	Driving
Typing	Scooping	House chores	Exercise	Lying prone	Stair stepping

Does the pain shift or radiate from original location?_____

Sitting	Standing	Lying	Knees bent up	Support
No movement	Movement	Heat	Ice	Analgesic topical
Ibuprofen	Medication	Rest	Stretching/exercise	Adjustments

Allergies/Medication

Are you currently taking any medication/supplements? (circle one) Yes No

If yes, what kind(s) and dosage?_____

_____

Prescribing physician?_____ Phone #: (_____)_____-_____

Are you allergic to any food/ medication? (circle one) Yes No

If yes, what food/medication?_____

_____

Any hospitalization in the past year? (circle one) Yes No Reason? _____

Surgical history: Date____/___/_____ Detail?_____ (circle one) In Patient Out Pa-

Social History

Do you smoke? (circle one) Yes No Date Started _____/_____/_____ Number of Packs per Day? _____

Date Quite Smoking?___/___/_____

Do you consume alcohol? (circle one) Yes No Frequency?_____ Type?_____

Do you consume caffeine? (circle one) Yes No Frequency?_____

Do you drink soda? (circle one) Yes No Frequency?_____

Do you drink water daily? (circle one) Yes No Frequency?_____

How much sleep do you average per night?_____

How often do you take pain relievers?_____ per: Day Night Week Month

Recreational Drug Use? (circle one) Yes No Frequency?_____ Type?_____

Are you a healthy eater? (circle one, 1=not at all, 10=very) 0 1 2 3 4 5 6 7 8 9 10

Do you exercise? (circle one) Yes No Frequency?_____ per: Day Night Week Month

Physical Stress Level? (circle one, 1=not at all, 10=high) 0 1 2 3 4 5 6 7 8 9 10

Emotional Stress Level? (circle one, 1=not at all, 10=high) 0 1 2 3 4 5 6 7 8 9 10

Major Stressors?_____

Things to improve?_____

Health goals _____

Comprehensive Questionnaire

Section A: Gastrointestinal

N/A	Acute	Chronic	
O	O	O	Digestive Complaints
O	O	O	Stomach Complaints
O	O	O	Ulcers
O	O	O	Frequent Heartburn
O	O	O	Nausea
O	O	O	Frequent Diarrhea
O	O	O	Frequent Constipation
O	O	O	Irritable Bowel
O	O	O	Hemorrhoids
O	O	O	Frequent Vomiting
O	O	O	Colitis/Diverticulitis
O	O	O	Black or Bloody Stool
O	O	O	Gallbladder Trouble
O	O	O	Frequent Burping/Belching

Section B: Immune Response

N/A	Acute	Chronic	
O	O	O	Frequently Sick
O	O	O	Frequent Swollen Glands/Sore Throat
O	O	O	Depression and/or Anxiety
O	O	O	Achy Joints/Muscle Pain
O	O	O	Headaches/Migraines
O	O	O	Recurrent Digestive Complaints
O	O	O	Chronic Fatigue
O	O	O	Food Allergies
O	O	O	Eczema or Hives
O	O	O	Allergies (mild/moderate/severe)

Comprehensive Questionnaire Continued

Section C: Structural/Neurological

N/A	Acute	Chronic	
O	O	O	Headaches
O	O	O	Muscle Cramps/Muscle Spasms
O	O	O	Neck Pain
O	O	O	Jaw Pain
O	O	O	Dizziness
O	O	O	Back Pain
O	O	O	Shoulder/Elbow/Wrist Pain (circle one)
O	O	O	Numbness/Tingling
O	O	O	Tremors in Hands or Feet
O	O	O	Knee Pain/Hip Pain (circle one)
O	O	O	Joint Pain or Loss of Function
O	O	O	Osteoporosis/Osteomalacia
O	O	O	Current Bone Fracture or Injury
O	O	O	Tendonitis/Bursitis

Section D: Cardiovascular

N/A	Acute	Chronic	
O	O	O	Irregular Heartbeat
O	O	O	Heart Murmur/Palpitations
O	O	O	High or Low Blood Pressure
O	O	O	Chest Pain
O	O	O	Previous Heart Trouble
O	O	O	Poor Circulation
O	O	O	Previous Heart Surgery
O	O	O	Varicose or Spider Veins
O	O	O	Hands and Feet Cold All the Time

Section E: Respiratory

N/A	Acute	Chronic	
O	O	O	Chronic Cough
O	O	O	Asthma
O	O	O	Emphysema
O	O	O	Recurrent Head Colds
O	O	O	Recurrent Sinus Infections
O	O	O	Recurrent Bronchitis
O	O	O	Smoker

Section F: Genito-Urinary

N/A	Acute	Chronic	
O	O	O	Too Frequent Urination
O	O	O	Discolored or Foul-Smelling Urine
O	O	O	Blood in Urine
O	O	O	Recurrent Kidney or Bladder Infections
O	O	O	Kidney Stones
O	O	O	Bedwetting
O	O	O	Inability to Control Bladder

Section G: Eyes/Ears

N/A	Acute	Chronic	
O	O	O	Recurrent Ear Infections
O	O	O	Eye Infection
O	O	O	Slowly Losing Vision
O	O	O	Floaters in Eyes
O	O	O	Glaucoma
O	O	O	Macular Degeneration
O	O	O	Cataracts
O	O	O	Diabetic Retinopathy

Section H: Men

N/A	Acute	Chronic	
O	O	O	Prostate Trouble
O	O	O	Urination Problems
O	O	O	Reproductive Problems

Section H: Women

N/A	Acute	Chronic	
O	O	O	Recurrent Urinary Tract Infections
O	O	O	Yeast Infections
O	O	O	Vaginal Discharge
O	O	O	Menstrual Irregularity
O	O	O	Cramping
O	O	O	Mood Swings/Depression
O	O	O	Pre-menstrual Syndrome
O	O	O	Infertility
O	O	O	Frequent Miscarriages
O	O	O	Hot Flashes
O	O	O	Currently Taking Hormone Medication
O	O	O	Currently Taking Birth Control Pills
O	O	O	Lumps in Breasts
O	O	O	Uterine Cysts/Ovarian Cysts
O	O	O	Bladder Leaks Too Easily
O	O	O	Endometriosis

Section I: Endocrine (Glandular)

N/A	Acute	Chronic	
O	O	O	Cold Hands and Feet
O	O	O	Low Blood Pressure
O	O	O	Weight Problems (over or under)
O	O	O	Thyroid Problems
O	O	O	Diabetes
O	O	O	Irritable if Meals are Missed
O	O	O	Anxiety/Nervousness/Irritability
O	O	O	Dizzy Upon Standing too Quickly
O	O	O	Weak and Shaky
O	O	O	Hyperactive Behavior
O	O	O	Depression
O	O	O	Very Susceptible to Infections
O	O	O	Frequent Headaches
O	O	O	Digestive Complaints

Family History

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Age *(if still alive)*											
Age at Death *(if deceased)*											
Cancers											
Colon Cancer											
Breast or Ovarian Cancer											
Heart Disease											
Hypertension											
Obesity											
Diabetes											
Stroke											
Inflammatory Arthritis *(Rheumatoid, Psoriatic, Ankylosing Spondylitis)*											
Inflammatory Bowel Disease											
Multiple Sclerosis											
Auto Immune Diseases *(such as Lupus)*											
Irritable Bowel Syndrome											
Celiac Disease											
Asthma											
Eczema / Psoriasis											
Food Allergies, Sensitivities, or Intolerances											
Environmental Sensitivities											
Dementia											
Parkinson's											
ALS or other Motor Neuron Diseases											
Genetic Disorders											
Substance Abuse *(such as Alcoholism)*											
Psychiatric Disorders											
Depression											
Schizophrenia											
ADHD											
Autism											
Bipolar / Mood Disorder											
Other:											

Diet

Do you have known adverse food reactions, allergies, or sensitivities? □ Yes □ No *If yes, describe symptoms and list all foods:*

_____

_____

Do you have an adverse reaction to caffeine? □ Yes □ No

When you drink caffeine do you feel: □ Irritable or Wired □ Aches & Pains □ Headaches

Do you adversely react to: *Check all that apply*

□ Monosodium Glutamate *(MSG)* □ Aspartame *(NutraSweet)* □ Preservatives *(ex. sodium benzoate)*

□ Cheese □ Citrus foods □ Chocolate □ Alcohol □ Red Wine □ Caffeine □ Bananas □ Garlic □ Onion

□ Sulfite containing foods *(wine, dried fruit, salad bars)* □ Other: _____

Environmental & Detoxification Assessment

Which of these significantly affect you? *Check all that apply*

□ Cigarette Smoke □ Perfumes/Colognes □ Auto Exhaust Fumes □ Other: _____

In your home or work environment, are you exposed to: □ Chemicals □ Electromagnetic Radiation □ Mold

How often do you use your cell phone? ____ $^{hrs}/_{day}$ How often do you use your computer? ____ $^{hrs}/_{day}$ ____ $^{hrs}/_{wk}$

Have you ever turned yellow *(jaundiced)*? □ Yes □ No

Have you ever been told you have Gilbert's syndrome or a liver disorder? □ Yes □ No

If yes, explain _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

□ Herbicides □ Insecticides *(frequent visits of exterminator)* □ Pesticides □ Organic Solvents

□ Heavy Metals □ Other _____

Chemical *Name/Date/Length of Exposure (if known)* _____

Do you dry clean your clothes frequently? □ Yes □ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? □ Yes □ No

Do you have any pets or farm animals? □ Yes □ No

What detergents/soaps do you use *(Brand names)*? _____

What deodorant? _____

What beauty products do you use *(Lotions, Hair products, Make-up, etc.)*? _____

Readiness Assessment

In order to improve your health, how willing are you to: *Rate on a scale of: 5 (very willing) to 1 (not willing)*

Significantly improve your diet _____ □5 □4 □3 □2 □1
Take several nutritional supplements each day _____ □5 □4 □3 □2 □1
Start preparing your own meals _____ □5 □4 □3 □2 □1
Modify your lifestyle _____ □5 □4 □3 □2 □1
Practice a relaxation technique _____ □5 □4 □3 □2 □1
Engage in regular exercise _____ □5 □4 □3 □2 □1
Have periodic lab tests to assess your progress _____ □5 □4 □3 □2 □1
Get regular bodywork such as chiropractic or massage _____ □5 □4 □3 □2 □1
Setting regular appointments _____ □5 □4 □3 □2 □1
Read books or articles to learn about your health and solutions _____ □5 □4 □3 □2 □1
Be fully responsible for your own healing _____ □5 □4 □3 □2 □1

Comments: _____

_____

How confident are you of your ability to organize and follow through on the above health related activities? *Rate on a scale of: 5 (very confident) to 1 (not confident at all)* □5 □4 □3 □2 □1 *If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?*

_____

_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? *Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)* □5 □4 □3 □2 □1 *Comments:*

_____

_____How much ongoing support and contact *(office visits)* from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)* □5 □4 □3 □2 □1 *Please list how often you would be willing to make appointments if needed* _____

Comments: _____

_____

_____

Credit Card Information

In our office services are frequently rendered in anticipation of payment from a health reimbursement account or an insurance company. Any time services are rendered without immediate payment credit is extended. We ask you to guarantee that credit with a personal credit card. Please be assured your card will NEVER be charged without your prior notification.

Please initial each paragraph after you have read it. Thank you.

_____In the event that my insurance company refuses payment to CT Chiropractic for any reason, I will become personally responsible for that amount. I will have 30 days (once notified by CT Chiropractic) to take care of the outstanding balance by calling my insurance company. If the account is not cleared within 30 days, I am responsible to pay the balance due. I hereby authorize CT Chiropractic to collect any outstanding balance from my credit card (listed below), if I fail to pay the balance due within 30 days.

_____ I will promptly bring any insurance checks that I receive to the office of CT Chiropractic. If I fail to do so within 1 week of receiving it, I understand that my credit card (listed below) may be charged for the amount owed.

_____If my insurance company fails to pay any portion of my bill, and I do not make payment within 30 days of being notified by CT Chiropractic, I give my permission for CT Chiropractic to charge the credit card (listed below) for the balance due.

_____Any balance on my account will be paid for and cleared within 30 days of notification of the amount. If a balance remains past 30 days, I hereby authorize CT Chiropractic to collect the amount in full by charging the credit card listed below.

The signed credit card is only to be used for services rendered at CT Chiropractic.
The doctor agrees not to add any charges directly to my account
for services that were not performed or products not purchased.

Patient Name:_____

Address:_____City:_____State:_____Zip:_____

Credit Card: Visa_____ MasterCard_____

Credit Card Number:_____

Expiration:_____ CVV:_____ Billing Zip_____

Patient Signature:_____ Date:_____

Witness Signature:_____Date:_____

Terms of Acceptance

_____ When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method of chiropractic care in order to attain results. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during your course of chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those finding, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____It is the practice of this office to provide chiropractic care in an "OPEN ADJUSTING" environment. Some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

Authorization for Care

_____I Authorize the Doctor, Kelli Dodge D.C., to work with my condition through the use of adjustments to my spine, as she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payments. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

Health Insurance Coverage

_____I clearly understand that my health insurance is a contract between me and my health insurance company. I understand that this office is providing me with complimentary service by billing my insurance company for me. I agree that any services rendered that are not covered by my insurance policy are solely my financial responsibility.

I, _____ have read, and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office (CT Chiropractic & Wellness Center) have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Sign: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES DISCLOSURE

CT Family Chiropractic, LLC

Please read and understand the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY following this disclosure.

Please indicate with whom we can discuss health information, appointment scheduling and/or billing.

Spouse:_____ ☐ Yes, Health ☐ Yes, Billing ☐ Yes, Scheduling

Parent/s or Guardian/s: _____ Indicate Relationship: _____

☐ Yes, Health ☐ Yes, Billing ☐ Yes, Scheduling

Relative/Friend/Other: _____ Indicate Relationship: _____

☐ Yes, Health ☐ Yes, Billing ☐ Yes, Scheduling

Acknowledgment of Receipt of this Notice As a patient of CT Family Chiropractic, I acknowledge that I have read the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY and understand that I may request a copy of the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY for detailed information. I understand that CT Family Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree with all conditions stated in the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY.

Printed Name: _____

Signature of Patient: _____ Date: _____/_____/_____

(Parent or Guardian Signature if Patient is a Minor)