

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
SS#: - -	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F
Marital Status:	# of Children:	Occupation:
Street Address:	Height: ft. in.	
City:	State:	Zip: Weight: lbs.
Email:	Cell Phone: - -	Other Phone: - -
Emergency Contact:	Emergency Relation:	Emergency Phone: - -
How did you hear about us?		
Who is your primary care physician?		
Date and reason for your last doctor visit:		
Are you also receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No		
- If yes, please name them and their specialty:		
Please note any significant family medical history:		

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Have you received care for this problem before? ☐ Yes ☐ No

- If yes, please explain:

When did the condition(s) first begin?

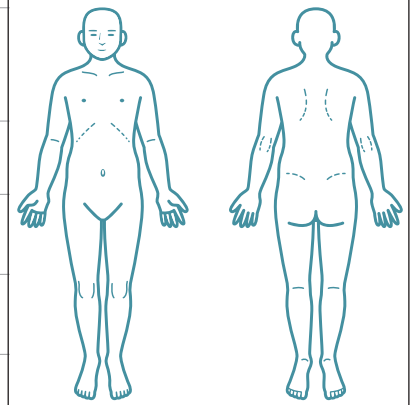
How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.



YOUR HEALTH GOALS

Your top three health goals:

1. _____
2. _____
3. _____

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?

What is their specialty? ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutritional ☐ Subluxation-based ☐ Other:

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 childhood 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, please explain:

Exercise Frequency? ☐ None ☐ 1-2x per week ☐ 3-5x per week ☐ Daily

What types of exercise?

How do you normally sleep? ☐ Back ☐ Side ☐ Stomach Do you wake up: ☐ Refreshed and ready ☐ Stiff and tired

Do you commute to work? ☐ Yes ☐ No If yes, how many minutes per day?

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:

	<i>None</i>						<i>None</i>				
	<i>None</i>	<i>Moderate</i>	<i>High</i>				<i>None</i>	<i>Moderate</i>	<i>High</i>		
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.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	<i>None</i>						<i>None</i>				
	<i>None</i>	<i>Moderate</i>	<i>High</i>				<i>None</i>	<i>Moderate</i>	<i>High</i>		
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ Date: ____ / ____ / ____

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Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS			
		PAST PRESENT	PAST PRESENT		
Cervical	• Autonomic Nervous System	<input type="checkbox"/> <input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/> <input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/> <input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/> <input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/> <input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/> <input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/> <input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/> <input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/> <input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/> <input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/> <input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/> <input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/> <input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/> <input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/> <input type="checkbox"/>	Stiff Neck & Shoulders
			<input type="checkbox"/> <input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/> <input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/> <input type="checkbox"/>	Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I.	<input type="checkbox"/> <input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/> <input type="checkbox"/>	Bronchitis & Pneumonia
	• Respiratory System	<input type="checkbox"/> <input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/> <input type="checkbox"/>	Functional Heart Conditions
	• Cardiac Function	<input type="checkbox"/> <input type="checkbox"/>	Asthma		
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/> <input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/> <input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/> <input type="checkbox"/>	Fever	<input type="checkbox"/> <input type="checkbox"/>	Blood Sugar Problems
Lower Thoracic	• Stress Response	<input type="checkbox"/> <input type="checkbox"/>	Behavior Issues	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/> <input type="checkbox"/>	Hyperactivity	<input type="checkbox"/> <input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/> <input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Chronic Stress	<input type="checkbox"/> <input type="checkbox"/>	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/>	Sciatica & Radiating Pain
		<input type="checkbox"/> <input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/> <input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Gut-Immune System	<input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Hamstring Tightness
	• Major Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Bed-wetting	<input type="checkbox"/> <input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/> <input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/> <input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/> <input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/> <input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/> <input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/> <input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/> <input type="checkbox"/>	Infertility	<input type="checkbox"/> <input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/> <input type="checkbox"/>	Impotency	<input type="checkbox"/> <input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: _____

Date: ____ / ____ / ____



Doctor-Patient Relationship in Chiropractic Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions if you do not understand.

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic healthcare services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When such VSCs are found, chiropractic adjustments and ancillary procedures may be given in order to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of your body.

DIAGNOSIS

Although Doctors of Chiropractic are experts in chiropractic diagnosis of the VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, and will gladly refer you to the appropriate medical specialist; however you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. The doctor will make every reasonable effort during their examination to screen for such contraindications; however it is the responsibility of the patient to make it known or to learn through health care procedures whether he/she is suffering from latent pathological defects, illnesses, or deformities that would otherwise not come to the attention of the Doctor of Chiropractic. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory, response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. The science of Chiropractic and Medicine may never be so exact as to provide definitive answers to all problems. Among other things, Chiropractic care may reduce pain, increase mobility and improve quality of life.

CERTIFICATION

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if not care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR NATE BLUME AND/OR DR STACI BLUME TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient Signature

Date

Witness Signature

Consent of Treatment of Minor Child

I, _____ hereby authorize Drs. Blume and whomever they may designate as their assistant to administer chiropractic care as deemed necessary to my minor child or dependent. In addition, by signing below, I give my permission for the above-named patient to be managed by the doctor even when I am not present to observe such care.

Patient Name: _____ Age: _____ DOB: _____

Authorized Signatory: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Signature On File

- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I permit a copy of this authorization to be used in place of the original.

Name (please print)

Signature: _____ Date: _____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Cell Phone: _____ Alternate Phone: _____