Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name: | Last Name: | Date: / /

SS#: - - | DOB: / / | Sex: ○ M ○ 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? ○ Yes ○ No

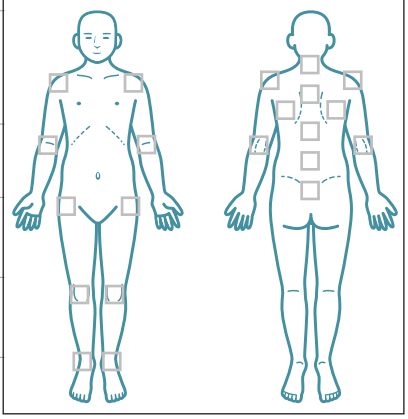
- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

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

Please indicate where you are experiencing pain or discomfort.



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

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:

	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.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
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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Pregnancy Questionnaire

Patient Name: _____ Date: ___/___/___

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ☐ Yes ☐ No

- If not, please tell us about your previous pregnancy and/or birth experience(s).

Do you plan to follow the same plan as your previous delivery? ☐ Yes ☐ No

- If no, what would you like to change?

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date?

Did you have any difficulty conceiving? ☐ Yes ☐ No

- If yes, please explain:

Have you ever used any form of hormonal or oral contraceptives? ☐ Yes ☐ No

- If yes, which ones, and for how long?

When was your last menstrual cycle?

What was your pre-pregnancy weight? lbs. Current weight? lbs.

Have you experienced morning sickness? ☐ Yes ☐ No

- If yes, please explain:

CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently performing?

Please tell us about your current diet, and any dietary restrictions.

Have you taken any medications or supplements during your pregnancy? ☐ Yes ☐ No

- If yes, please explain:

Have you had any slips, falls, or other physical traumas during the pregnancy? ☐ Yes ☐ No

- If yes, please explain:

Have you had any major emotional stressors during your pregnancy? ☐ Yes ☐ No

- If yes, please explain:

YOUR BIRTH PLAN

You top three goals for this pregnancy:

1. _____
2. _____
3. _____

Do you currently have a birth plan? ☐ Yes ☐ No

- If yes, please explain:

Are you taking any pre-natal or birthing classes? ☐ Yes ☐ No

- If yes, please explain:

Who is your OB/GYN or midwife? Will they be present for delivery? ☐ Yes ☐ No

Who is your birth provider?

Do you intend to have a doula or birth coach present? ☐ Yes ☐ No

- If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? ☐ Yes ☐ No

- If not, what concerns do you have?

YOUR POST-BIRTH PLAN

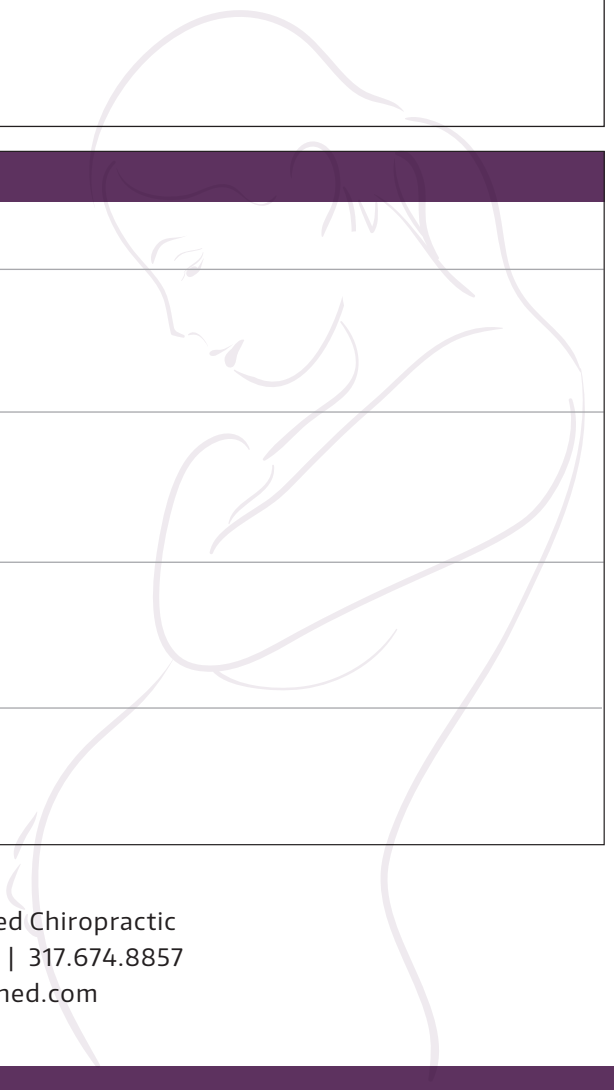
Do you plan on breastfeeding your child? ☐ Yes ☐ No

What do you intend to do for vaccines?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

What would you like to gain from chiropractic care during your pregnancy?

Are there any burning questions you want to be sure to ask today?



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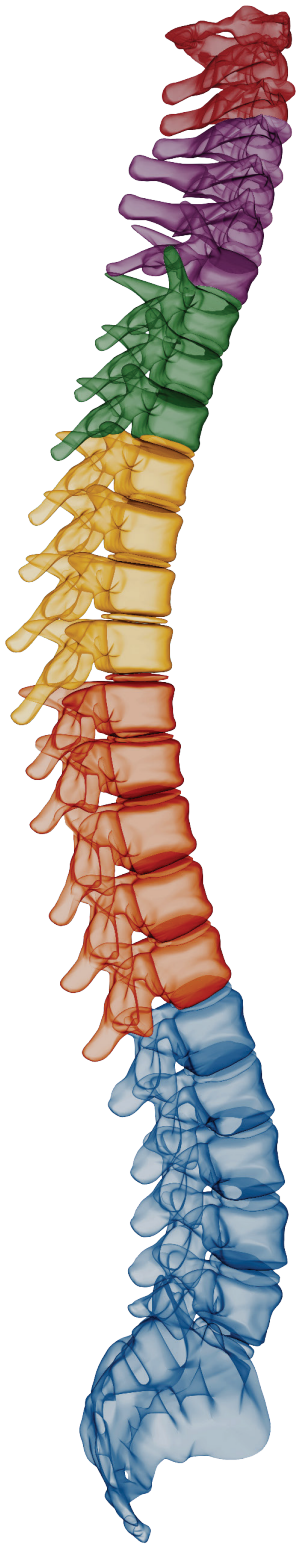
Patient Review of Systems

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

Patient Name: _____ Date: ___/___/___

L(FE REF)NED
CHIROPRACTIC

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 note 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 not 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:_____