Chiropractic Health Questionnaire

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ E-Mail: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Insurance Company: _____ Policy Number: _____

Policy Holder (name & DOB) _____ Group Number: _____

Medical Doctor: _____ Height: _____ Weight: _____

Marital Status: **M W D S** Spouse's Name: _____ # of Children: _____

Emergency Contact (name & number) _____

1. Most patients are referred to our office by a caring family member or friend. Whom may we thank for referring you? _____

□ Telephone Call □ Sign □ Website □ Presentation □ Newspaper □ Other _____

2. Research shows that your spine should be checked regularly.

How many times have you visited a chiropractor in your lifetime? _____ □ Never

3. When was your last complete set of spinal X-rays? _____ □ Never

4. Poor posture leads to poor health and often indicates a spinal problem.

How would you rate your posture? (POOR) 1 2 3 4 5 6 7 8 9 10 (EXCELLENT)

5. Stress can cause or accelerate spinal damage.

Rate your stress level over the last 90 days (LOW) 1 2 3 4 5 6 7 8 9 10 (HIGH)

6. Please list any health symptoms or health complaints you are experiencing.

1. _____ 2. _____ 3. _____

7. Spinal problems [Subluxation] can exist for years without detection, with the pain coming later.

When did your body signal appear? _____

8. What makes the pain feel worse? _____

Better: _____

9. Favorite hobbies or interests: _____

10. Prescription medications and surgeries may cause various side effects, hide the severity of health problems and hinder the body's ability to heal.

Please list current medications: _____

Please list surgeries: _____

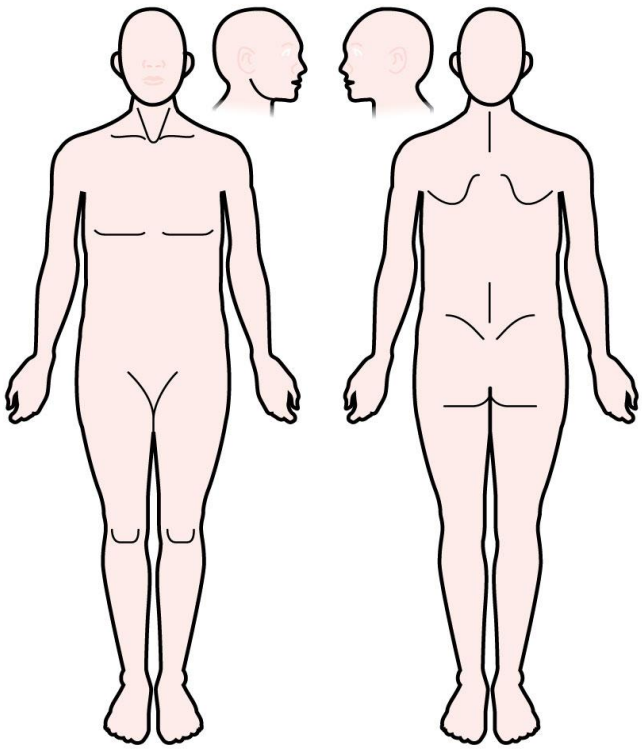
Please list hospitalizations: _____

12. Is this visit related to an automobile accident or work injury? □ YES □ NO Date of Incident _____

13. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? □ YES □ NO

Subluxation can put pressure on nerves and spinal cord. Mark the areas on your body where you feel your pain. Use appropriate **letters** listed below.

A= Ache **N**= Numbness **S**= Sharp/Stabbing **B**= Burning **D**= Dull **R**= Radiating **P**= Pins/Needles



Please place a slash through the line that will correspond to your immediate pain.

NO PAIN ——————————————— WORST PAIN POSSIBLE

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

_____ _____ ___/___/___

Print Patient's Name Signature Date

HIPAA PRIVACY AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization affects your rights regarding your privacy of your personal healthcare information.

I understand that my treatment, payment, enrollment or eligibility of benefits will not be affected by my signing or not signing the form.

PLEASE SELECT OPTION A OR B:

- **A:** I authorize Proactive Chiropractic Group to use and/or disclose my protected health information described below for the purpose of treatment and care (initial **ONE**)

  ____ My complete health record INCLUDING treatment information for mental health, drug/alcohol abuse, and communicable diseases

  ____ My complete health record EXCLUDING treatment information for mental health, drug/alcohol abuse, and communicable diseases

This information can be shared with the following family members or loved ones:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- **B:** Please DO NOT disclose or discuss my medical records or private information to anyone, including family members and loved ones. **This option is not available for minors, we must have written documentation disclosing the adult caregiver's information.**

_____ _____ ___/___/___
Print Patient's Name Signature Date

_____ _____ ___/___/___
Representative Relationship Date

Witness to Patient's Signature: _____ Date: ___/___/___

Proactive Chiropractic Group
12426 S Van Dyke Road
Plainfield, IL 60585

Phone: 815-782-6903 Fax: 815-782-6981

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by working or associated with the doctor of chiropractic named above, including those working at the clinic office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, discolorations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on facts then known, is in my best interest.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

TO BE COMPLETED BY PATIENT OR PATIENTS REPRESENTATIVE, IF NECESSARY, E.G. IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED.

_____	_____	____/____/____
Print Patient's Name	Signature	Date
_____	_____	____/____/____
Representative	Relationship	Date

Witness to Patient's Signature: _____

Date: ____/____/____

Past and Present Conditions

Patient Name: _____ Date of Birth: _____

Using the codes listed below, please fill in **every** blank with the applicable letter.

Check to indicate if you have pain or stiffness and on which side of your body. If both sides apply, please check R & L.

P = **P**ast health condition **C** = **C**urrent health condition **N** = **N**ever had this health condition

Example: __C__ Shoulder ☑ Pain ☐ Stiff ☑ R ☐ L

Extremities:	***Location:***	***Respiratory:***	***Other Condition:***
____ Hip	☐ Pain ☐ Stiff ☐ R ☐ L	____ Asthma	____ Headaches/Migraines
____ Knee	☐ Pain ☐ Stiff ☐ R ☐ L	____ Chest Pain	____ Trouble sleeping
____ Foot	☐ Pain ☐ Stiff ☐ R ☐ L	____ Difficulty Breathing	____ Excessive sweating
____ Shoulder	☐ Pain ☐ Stiff ☐ R ☐ L	____ Lung Problems	____ Cancer *(type)*: _____
____ Elbow	☐ Pain ☐ Stiff ☐ R ☐ L	____ COPD	____ Emotional/mental disorders
____ Wrist	☐ Pain ☐ Stiff ☐ R ☐ L	***Digestion:***	____ Learning disability
____ Jaw Pain	☐ Pain ☐ Stiff ☐ R ☐ L	____ Heartburn	____ Nervousness/Irritability
____ Swollen or painful joints	☐ Pain ☐ Stiff ☐ R ☐ L	____ Digestion problems	____ Memory Loss
Spine:		____ Gallbladder problems	____ Dizziness/Loss of balance
____ Head/Shoulders feel heavy and/or tired		____ Colon trouble	____ Arthritis
____ Neck	☐ Pain ☐ Stiff ☐ R ☐ L	____ Diarrhea/Constipation	____ Epilepsy/Convulsions
____ Upper Back	☐ Pain ☐ Stiff ☐ R ☐ L	____ Hemorrhoids	____ Knocked unconscious
____ Mid Back	☐ Pain ☐ Stiff ☐ R ☐ L	***Immune System:***	____ Frequent ear infections
____ Low Back	☐ Pain ☐ Stiff ☐ R ☐ L	____ Skin problems	____ Ringing in ear ☐ R ☐ L
____ Pain with cough, sneeze, or strain with bowel movement Location of pain: _____		____ Sinus issues/allergies	____ Hearing loss ☐ R ☐ L
		____ Frequent colds/flu	____ Trouble concentrating
Other: _____		____ Anemia	____ AIDS/HIV
		____ Other: _____	____ Fracture/dislocation of bones (*where*):
Numbness/Tingling or Pain in:		***Organ Issues/Dysfunctions:***	***Urinary Tract:***
____ Arm	☐ Pain ☐ Numb ☐ R ☐ L	____ Diabetes	____ Kidney trouble
____ Hand/Fingers	☐ Pain ☐ Numb ☐ R ☐ L	____ Liver Trouble	____ Frequent Urination
____ Legs	☐ Pain ☐ Numb ☐ R ☐ L	____ Hepatitis	____ Bedwetting
____ Foot/Toes	☐ Pain ☐ Numb ☐ R ☐ L	____ High or low blood pressure	____ Other: _____
Male:		***Female:***	***Social History:***
____ Impotence		____ Menopausal problems	____ Smoking (how much/often)
____ Prostate problems		____ Menstrual cycle problems	____ Alcohol (how much/often)
			____ Rec drugs (how much/often)
			____ Exercise (type/how often)

Patient/Guardian's Signature: _____ Date: _____/_____/_____

Doctor's Signature: _____ Date Form Received: _____/_____/_____

VISUAL ANALOGUE SCALE

Patient Name: _____ Date of Birth: _____

Please read carefully—

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

No pain		Headache			Neck			Low Back		**Worst possible pain**
0	1	(2)	3	4	(5)	6	7	(8)	9	10

1.) What is your pain *right now*?

No pain										**Worst possible pain**
0	1	2	3	4	5	6	7	8	9	10

2.) What is your *typical* or *average* pain?

No pain										**Worst possible pain**
0	1	2	3	4	5	6	7	8	9	10

3.) What is your pain at *its best* (how close to "0" does your pain get)?

No pain										**Worst possible pain**
0	1	2	3	4	5	6	7	8	9	10

4.) What is your pain level at *its worst* (how close to "10" does your pain get)?

No pain										**Worst possible pain**
0	1	2	3	4	5	6	7	8	9	10

Other Comments: _____

_____

_____

X-RAY CONSENT

The doctor has explained that the purposes of the x-rays to be taken are to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-ray, I will be informed. I understand that I will then need to make the decision to seek additional advice from another health care provider for the "unusual finding". I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

Consent to Evaluate a Minor Child (If Applicable)

☐ I, _____ (parent/legal guardian), of _____ (child's name) hereby grant permission for my child to receive chiropractic examinations and x-rays.

***Males**: Please skip to the bottom of the page and print/sign document*

***Females**: Please choose which option best applies*

Pregnancy Release

☐ By my signature, I am acknowledging that the doctor or member of the staff has discussed with me the risks of ionization to an unborn child, and I have conveyed my understanding of the risks of being exposed to x-rays. To the best of my knowledge, I am NOT pregnant, and after careful consideration, I do hereby consent to have x-rays taken.

☐ I am pregnant, therefore I am NOT getting x-rays.

_____ _____ ___/___/___
Print Patient's Name Signature Date

_____ _____ ___/___/___
Representative Relationship Date

Witness to Patient's Signature: _____ Date: ___/___/___