EXPERIENCE life CHIROPRACTIC

Adult Questionnaire

CONFIDENTIAL INFORMATION

First Name: Last Name: Date:

Street Address: City, State, Zip:

Phone Number: Email:

SSN: Age: Birthdate: Sex: M F

Marital Status: Occupation:

Number of Children: Children's names and ages:

Emergency Contact: 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 receiving care from any other health professionals? Yes No

-If yes, please name them and their specialty:

CURRENT HEALTH CONDITIONS

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

Have you received care for the this before? Yes No

-If yes, please explain:

When did the concern(s) first begin?

How did the concern start? Suddenly Gradually Post-Injury

Is this concern: Getting worse Improving Intermittent Constant Unsure

What makes the challenge better?

What makes the challenge 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 concern(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?

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

Toxins: Chemicals & 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

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NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosure.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to regular privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician's certifications

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (printed):	Relationship to Patient:
Signature:	Date:

INFORMED CONSENT

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce subluxations. **Vertebral subluxation** is a disturbance in the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

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 no 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. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY ATHORIZE DR. SHEENA NAGELI TO PROCEED WITH CHIROPRACTIC CARE DATED THIS _____ DAY OF _____ 20_____.

Patient Signature:	Doctor's signature:

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