BALANCED LIFE
CHIROPRACTIC

Adult Health Questionnaire (Ages 13+)

Name: _____ Date: _____ Birthdate: _____

Address: _____
Residence and mailing City State Zip Code

Home Phone:(_____)_____ Cell Phone:(_____)_____ ☐ Male ☐ Female

Email Address: _____ Occupation: _____

Spouse's Name: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who may we thank for referring you to our office? _____

Health History

Reason for seeking care in our office? _____

_____

Are you under the care of any other doctor? (Medical, Chiropractic, Other) ☐ Yes ☐ No

If Yes, the conditions being treated for: _____

List any current medications: _____

List any past surgeries and dates: _____

List any past accidents and dates: _____

List any injuries you have had: _____

Have you ever been adjusted by a chiropractor? ☐ Yes ☐ No

Have you ever been on a chiropractic maintenance plan? ☐ Yes ☐ No

Potential Causes of Subluxations

✓ Any stressors you have encountered in the last year:

Traumas (Physical)	Toxins (Chemical)	Thoughts (Emotional)
___ Slips/Falls	___ Medications	___ Work
___ Sports	___ Nicotine	___ Rush-hour traffic
___ Lifting	___ Alcohol	___ Taxes
___ Prolonged sitting	___ Soda	___ Bills
___ Sleeping in weird positions	___ Fast food	___ Arguments
___ Manual labor	___ Microwavable meals	___ Deadlines
___ Housework	___ Energy drinks	___ Busy schedules
___ Pregnancy	___ Sugar	___ Sickness/Death in family
___ Other	___ Other	___ Other

Health Inventory

✓ If you have experienced any of the following in the last year:

___ Fatigue
___ Sleeping problems
___ Frequent colds
___ Asthma
___ Allergies
___ Digestion problems
___ Weakness
___ Dizziness
___ Headache
___ Migraines
___ Nausea
___ Fainting
___ Neck pain
___ Shoulder pain
___ Upper back pain
___ Mid back pain
___ Low back pain
___ Hip pain
___ Knee pain
___ Leg/foot pain
___ Arm/hand pain
___ Numbness in hands/fingers
___ Numbness in feet/toes
___ Cold hands/feet
___ Loss of balance
___ Earaches/Ringing in ear
___ Depression
___ Anxiety
___ Lights bother eyes
___ Menstrual irregularity
___ Menstrual pain
___ Hot flashes
___ Brain fog
___ Difficulty focusing
___ Unexplained weight loss/gain
___ Other

Personal Health Assessment

Place an X where you are currently and put an O where you would like to be:

Disease/ Sickness	Symptoms/ PAIN	No Symptoms/ NO Pain	100% Alive Healthy

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date

For Doctor's Use Only

_____

_____

_____

_____

_____

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Informed Consent for Chiropractic Care

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 and treatment 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 spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to 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. A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, nervous system scans, palpation, and/or radiological examination (x-rays). 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, but may be performed by handheld instrument. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care. Risks associated with chiropractic treatment may include soreness, musculoskeletal sprain/strain, and/or 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. You are being informed of this reported association because a stroke may cause 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. Alternative treatments have been explained, including the risks, consequences and 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 PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED. HAVING THIS KNOWLEDGE, I AUTHORIZE TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____

Print Name Date

_____

Signature

Consent for Minor Patient:

I, _____being the parent or legal guardian of _____have read and understand the above Informed Consent and grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

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HIPAA Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define 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 disclosures. You may inspect and receive copies of your records within 30 days of request. You may request to view charges 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 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, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

_____ _____

Print Name Date

_____

Signature

Consent for Minor Patient:

I, _____ being the parent or legal guardian of _____

have read and fully understand the above HIPAA Form.

_____ _____

Print Name Date

_____

Signature