Adult Patient Questionnaire

Confidential Patient Information

First Name: Last Name: Date:

Street Address: City, State, Zip:

Home Phone: Cell Phone: Email:

DOB: Sex: ❍ M ❍ F How did you hear about us?

Occupation: Employer:

Emergency Contact: Emergency Relation: Emergency Phone:

Marital Status: # of Children: Height: Weight:

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:

For continuity of care, may we communicate with them? ❍ Yes ❍ No

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 first begin?

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

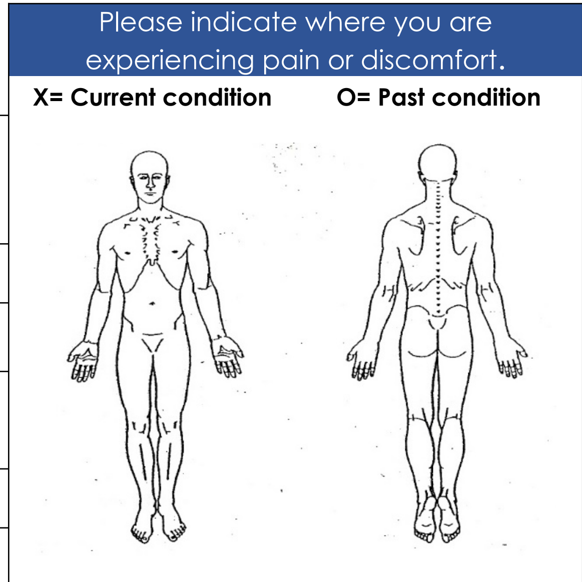
Is this condition: ❍ Getting worse ❍ Improving ❍ Intermittent ❍ Constant ❍ Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.

X= Current condition **O= Past condition**



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 was their specialty? ❍ Pain Relief ❍ Physical Therapy & Rehab ❍ Nutritional ❍ Subluxation-based

Do you have any other 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 or sports injuries? ❍ Yes ❍ No If yes, please explain:

Any auto accidents? ❍ Yes ❍ No If yes, please explain:

Exercise frequency? ❍ None ❍ 1-2x per week ❍ 3-6x 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 & Sweets	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

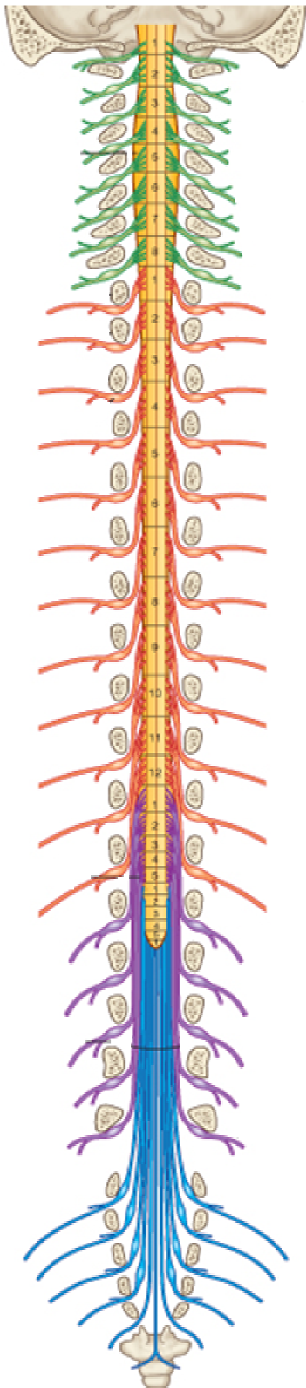
ACKNOWLEDGMENT AND CONSENT

Patient Name: ______________________ Date: __________

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 <u>PAST</u> and <u>PRESENT</u>***



REGIONS	PAST	PRESENT	SYMPTOMS	PAST	PRESENT	SYMPTOMS
Cervical	☐	☐	Colic & Excessive Crying	☐	☐	Pain, numbness & tingling In arms and hands
	☐	☐	Ringing Ear	☐	☐	Epilepsy & seizures
	☐	☐	Ear & Sinus Infections	☐	☐	Sensory & spectrum
	☐	☐	Hearing Loss	☐	☐	ADD / ADHD
	☐	☐	Allergies & Congestion	☐	☐	Focus & memory issues
	☐	☐	Eye Problems	☐	☐	Anxiety & Stress
	☐	☐	Immune Deficiency	☐	☐	Nervous breakdown
	☐	☐	Headache & Migraines	☐	☐	Mental/Emotional condition
	☐	☐	Vertigo & Dizziness	☐	☐	Balance & coordination
	☐	☐	Convulsions	☐	☐	Speech Issues
	☐	☐	Sore Throat & Strep	☐	☐	TMJ / Jaw Pain
	☐	☐	Hoarseness/Laryngitis	☐	☐	Stiff Neck & Shoulders
	☐	☐	Swollen Tonsils & Adenoids	☐	☐	Depression
	☐	☐	Tonsillitis	☐	☐	High / Low Blood Pressure
	☐	☐	Vision & Hearing Issues	☐	☐	Poor Metabolism & weight control
	☐	☐	Low Energy/Difficulty sleeping			

REGIONS	PAST	PRESENT	SYMPTOMS	PAST	PRESENT	SYMPTOMS
Upper Thoracic	☐	☐	Influenza	☐	☐	Pleurisy
	☐	☐	Reflux / GERD	☐	☐	Bronchitis & Pneumonia
	☐	☐	Chronic Colds & Cough	☐	☐	Congestion
	☐	☐	Croup	☐	☐	Functional Heart Conditions
	☐	☐	Asthma	☐	☐	Difficulty Breathing
	☐	☐	Thyroid Condition	☐	☐	Shortness of Breath

REGIONS	PAST	PRESENT	SYMPTOMS	PAST	PRESENT	SYMPTOMS
Mild Thoracic	☐	☐	Gallbladder Pain / Issues	☐	☐	Indigestion & Heartburn
	☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
	☐	☐	Fever	☐	☐	Blood Sugar / Diabetes
	☐	☐	Liver Condition	☐	☐	Arthritis

REGIONS	PAST	PRESENT	SYMPTOMS	PAST	PRESENT	SYMPTOMS
Lower Thoracic	☐	☐	Behavior Issues	☐	☐	Allergies & Eczema
	☐	☐	Hyperactivity	☐	☐	Skin Conditions / Rash
	☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
	☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating
	☐	☐	Shingles			

REGIONS	PAST	PRESENT	SYMPTOMS	PAST	PRESENT	SYMPTOMS
Lumbar, Sacrum & Pelvis	☐	☐	Constipation	☐	☐	Hemorrhoids
	☐	☐	Crohn's, Colitis & IBS	☐	☐	Hernias / Ruptures
	☐	☐	Diarrhea	☐	☐	Sciatica & Radiating Pain
	☐	☐	Dysentery	☐	☐	Lumbopelvic / SI Joint Pain
	☐	☐	Bed-Wetting	☐	☐	Hamstring Tightness
	☐	☐	Bladder & Urination Issues	☐	☐	Disc Degeneration
	☐	☐	Painful / Frequent Urination	☐	☐	Leg Weakness & Cramps
	☐	☐	Cramps & Menstrual Issues	☐	☐	Varicose Veins
	☐	☐	Cysts & Endometriosis	☐	☐	Poor Circulation & Cold Feet
	☐	☐	Miscarriages	☐	☐	Knee, Ankle & Foot Pain
	☐	☐	Infertility	☐	☐	Weak Ankles & Arches
	☐	☐	Change of Life Symptoms	☐	☐	Swollen Ankles
	☐	☐	Excessive Sweating	☐	☐	Lower Back Pain
	☐	☐	Impotency	☐	☐	Gluten & Casein Intolerance

HIPPA/Privacy Statement

Patient authorization regarding our open-door adjusting environment, sign-in sheets, travel card use and patient record of disclosures.

Our office uses sign-in sheets, travel cards and provides care in an "open door" adjusting environment. Adjustments are done in an open adjusting area. As a result, patients are in sight of each other and some ongoing routine details of care may be in earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity. In addition, your signature below authorizes us to contact you at all the phone numbers/address you listed on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Protecting the privacy of your personal health information is important to us. Disclosure of your personal 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 with a 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.

Patient Signature: ______________________ Date: ____________

Authorization for Care

I hereby authorize the doctors and staff at Health Journey Chiropractic to treat my condition as deemed appropriate. At Health Journey Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify the above information is correct to the best of my knowledge. I will not hold the doctors or any member of Health Journey Chiropractic staff responsible for any errors or omission I may have in the completion of this form. Chiropractic, as well as all other types of health care are associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Patient Signature: ______________________ Date: ____________

Parent or Guardian
Signature: (if minor) ______________________ Date: ____________

Referral Statement

Over 70% of our patients bring in their children to get adjusted. If you would like your children and/or spouse checked for subluxation, check the box below and they can receive a complimentary examination including computerized scan if scheduled within two weeks of starting care. **This exam is no cost to you** and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family members decide to receive care.

❍ I would like my family members checked for subluxations in the next two weeks.