

**Dynamic Balance Chiropractic**  
**Adult New Client Questionnaire**

**1. Please fill in the following Client Information:**

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Male  Female Date of Birth (mm/dd/yy) \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work/Home \_\_\_\_\_ Email \_\_\_\_\_

In the event that we need to reach you, what is the best time? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Hobbies and Interests \_\_\_\_\_

In case of emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_

Are you:  Single  Married / Common Law  Widowed  Separated  Divorced

Spouse/Partner Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Why did you choose this office? \_\_\_\_\_

What are your expectations from working with us? \_\_\_\_\_

Are you pregnant?  No  Don't Know  Yes, approximate due date: \_\_\_\_\_

Children's Names and Ages

1. \_\_\_\_\_ Age: \_\_\_\_\_ 4. \_\_\_\_\_ Age: \_\_\_\_\_

2. \_\_\_\_\_ Age: \_\_\_\_\_ 5. \_\_\_\_\_ Age: \_\_\_\_\_

3. \_\_\_\_\_ Age: \_\_\_\_\_ 6. \_\_\_\_\_ Age: \_\_\_\_\_

**2. Please tell us more about your current health situation:**

Do you have any issues keeping you from experiencing and enjoying your life as much as you would like?

In other words, do you currently have any symptoms?

No, I am here for continued health development and/or the ongoing pursuit of wellness.

Yes, I have some symptoms. (please list them below, in order of their effect on your life)

1. \_\_\_\_\_ How long? \_\_\_\_\_ Severity: (circle) High 10 9 8 7 6 5 4 3 2 1 Low

2. \_\_\_\_\_ How long? \_\_\_\_\_ Severity: (circle) High 10 9 8 7 6 5 4 3 2 1 Low

3. \_\_\_\_\_ How long? \_\_\_\_\_ Severity: (circle) High 10 9 8 7 6 5 4 3 2 1 Low

How have the above problems/symptoms affected your life? (How are you limited in your daily life?)

What else stands in the way of full expression of your health potential? \_\_\_\_\_

Current drugs or medications: \_\_\_\_\_

Please list any surgeries or hospitalizations you have had: \_\_\_\_\_

Please list any allergies/sensitivities you may have (drug or food): \_\_\_\_\_

Have you ever been to a Chiropractor before?  No  Yes: When? \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_

Address/ Phone: \_\_\_\_\_

Please list any other health care professionals currently treating you: \_\_\_\_\_

Compared to 5 years ago, are you:  More healthy  Less healthy  About the same

Are you satisfied with your current perceived overall health status?  Yes  No

What could **you** do to improve your health in the next 5 years? \_\_\_\_\_

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### 3. Family History

Please check if your mother, father or siblings have experienced any of these conditions:

	Mother	Father	Siblings
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other family history that you feel is important: \_\_\_\_\_

### 4. Are you seeking care as a result of an accident or injury? Yes No (If no, please skip to section 5)

Type of Accident/Injury:  Sports  Auto  Work  Other \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Details: (How did it happen?) \_\_\_\_\_

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### 5. Daily Habits

Exercise:  Heavy (Competitive Training)  Daily (4-7 times/wk)  Moderate (1-3 times/wk)  None

Work:  Heavy Labor  Light Labor  Standing  Sitting/Desk/Sedentary  Commute over 30 min

Habits: Coffee/Caffeine drinks:  None  Occasional  Daily \_\_\_\_\_ cups/day

Alcohol:  None  Occasional  Daily \_\_\_\_\_ drinks/week

Smoking:  None  Occasional  Daily \_\_\_\_\_ packs/day  I want to quit.

Please list any Vitamins/Herbs/Minerals you take: \_\_\_\_\_

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### 6. Have you ever had, or been diagnosed with:

<input type="checkbox"/> cancer: _____	<input type="checkbox"/> stroke / cerebrovascular accident	<input type="checkbox"/> carotid artery stenosis
<input type="checkbox"/> been in a car accident	<input type="checkbox"/> heart attack, angina, other heart problems	<input type="checkbox"/> polycystic ovarian syndrome
<input type="checkbox"/> had a spine or spinal cord injury	<input type="checkbox"/> gout	<input type="checkbox"/> scoliosis/abnormal spinal curves
<input type="checkbox"/> fracture or broken bone: _____	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> diabetes / pre-diabetes	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> infertility

### 7. Have you experienced:

<input type="checkbox"/> ongoing fatigue	<input type="checkbox"/> unexplained weight loss / gain	<input type="checkbox"/> frequent infections
<input type="checkbox"/> blurry vision	<input type="checkbox"/> frequent feeling of thirst	<input type="checkbox"/> numbness/tingling in hands or feet
<input type="checkbox"/> tinnitus / ringing in ears	<input type="checkbox"/> frequent urination	<input type="checkbox"/> sexual dysfunction

### 8. Responsible Party

Who is responsible for decisions related to the care of this client?  Myself

1. Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

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

Client (or Client's Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

Our Clinic is dedicated to assisting you in recovering your health naturally. Please review the following paragraphs and sign in the area provided.

I understand and agree that extended health benefits and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment to the Doctor. All fees are due at time of service unless otherwise arranged with the clinic directors in writing.

I hereby request and consent to the performance of Chiropractic examinations, adjustments and other chiropractic procedures such as diagnostic x-rays performed on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic or at an external imaging facility to which I am referred.

I have had an opportunity to discuss with the doctor of chiropractic/staff members 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 further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injury and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I acknowledge that I have had the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I understand that when I schedule an appointment for services at Dynamic Balance Chiropractic, that time is reserved for me and is not available to other clients. I understand that cancelling with less than 24 hours notice, or failing to appear for my scheduled appointments will result in me being charged for the services for which I am scheduled. I understand also that my insurance company will not reimburse me for “no-show” charges.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care. I reserve the right to withdraw my consent at any time with verbal or written notice of such a decision.

Email is used in our office to communicate with patients and to send our free monthly wellness newsletter.

I do not want any email from Dynamic Balance Chiropractic, including content regarding appointment reminders or changes, invoices for insurance reimbursement, or care recommendations.

I know I can unsubscribe at any time, but I do not wish to receive the free monthly wellness newsletter from Dynamic Balance Chiropractic.

**Client Signature:** \_\_\_\_\_  
(or Legal Guardian if under age 14)

**Signature of Witness:** \_\_\_\_\_  
(employee at Dynamic Balance Chiropractic)

**Print Patient Name:** \_\_\_\_\_

**Print Witness Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Date:** \_\_\_\_\_