Dynamic Balance Chiropractic
Adult New Patient Questionnaire

1. Please fill in the following Patient Information:

Patient Name_____ Date_____
□ Male □ Female Age_____ D.O.B._____
Address_____ City_____ Province_____ Postal Code_____
Home Phone_____ Work/Cell_____ 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_____
Whom may we thank for referring you to our office? _____
Are you: □ Single □ Married □ Common Law □ Widowed □ Separated □ Divorced
Spouse/Partner Name_____ D.O.B_____

Are you pregnant? □ No □ Don't Know □Yes, approximate due date_____
Children's Names and Ages

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____
5. _____ Age: _____
6. _____ Age: _____

2. Please tell us more about your current situation:

Why did you choose this office? _____
What are your expectations from working with us? _____

Do you have any issues keeping you from experiencing and enjoying your life as much as you would like? In other words, is something bothering you?

□ 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 has this affected your life? _____
2. _____ How long has this affected your life? _____
3. _____ How long has this affected your life? _____

What is the name of the last doctor that put you on a health development program? _____
Were you able to stick to that program? □ Yes □ No □ Never had a health development program
Please list any medications you currently take:_____
_____
Please list any surgeries or hospitalizations you have had:_____
_____
Please list any allergies/sensitivities you may have (drug or food):_____
_____
What else stands in the way of full expression of your health potential? _____
_____

Have you ever been to a Chiropractor before? □ No □ Yes: _____

Who is your family 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? _____
_____

3. Family History

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

	Mother	Father	Siblings
Diabetes	□	□	□
Heart Disease	□	□	□
Cancer	□	□	□
Arthritis	□	□	□

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)
Date of Accident_____
Type of Accident: □ Sports □ Auto □ Work □ Other_____
Details: (How did it happen?) _____
_____

5. Daily Habits

Exercise: □ Heavy (Competitive Training) □ Daily (4-7 times/wk) □ Moderate (1-3 times/wk) □ None
Work Activity: □ Heavy Labor □ Light Labor □ Standing □ Sitting/Desk/Sedentary
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:_____

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

□ cancer:_____	□ diabetes / pre-diabetes	□ high cholesterol
□ been in a car accident	□ stroke / cerebrovascular accident	□ high blood pressure
□ had a spine or spinal cord injury	□ heart attack, angina, other heart problems	□ carotid artery stenosis
□ fracture or broken bone	□ gout	□ polycystic ovarian syndrome

7. Have you experienced:

□ ongoing fatigue	□ unexplained weight loss / gain	□ frequent infections
□ blurry vision	□ frequent feeling of thirst	□ numbness/tingling in hands or feet
□ tinnitus / ringing in ears	□ frequent urination	□ sexual dysfunction

8. Responsible Party

Who is responsible for decisions related to the care of this patient? □ Myself
1. Name:_____ Relationship_____ Phone_____
2. Name:_____ Relationship_____ Phone_____

9. Payment for services rendered

To best serve you, we operate our office under the guidelines of "payment at the time of service". This allows our staff to focus their time and energy on your health care needs, and minimizes administrative efforts. This allows us to keep our costs (and yours) at a reasonable level. Thank you for honoring this system and fulfilling your financial obligations on the day that the services are performed.

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

Patient/Guardian Signature:_____ Date:_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

We use a multitude of techniques and tailor the care of our patients and practice members to their individual needs and limitations. We take great care to maximize results while minimizing risks. However, as in all forms of care and treatment, some risk is inevitable and unavoidable. In chiropractic care in general, some of the associated risks are listed below:

- As we seek to make changes in the way your body works, sometimes patients may experience a short term aggravation of their symptoms, muscle strains, or ligament sprains. If you have symptoms, they may get worse before they get better.
- While it has never occurred in our office, rib fractures have been reported as a result of manual adjustment of the midback. For patients with increased risk (osteoporosis, etc), we will alter the way in which we adjust these areas in order to minimize that risk.
- There are reported cases of cerebrovascular incidents or stroke that have been associated with many common neck movements, including painting a ceiling, backing up a car, having your hair washed at a salon, and manipulation of the cervical spine. The most up to date research does not show a causal relationship between chiropractic adjustment and stroke. We are, however, required to inform you of these reports. Strokes have potentially serious neurological impairments, and possible paralysis, no matter the cause. The possibility of such injury to happen after a visit to a chiropractic office has been shown to be the same as a visit to a medical office, and is extremely remote. No reputable study has shown that a stroke was caused by a chiropractic adjustment. We screen each patient for risk factors of stroke and modify our treatments to reduce risk of any sort.
- Rarely, there are reported cases associating an injury to the intervertebral disc following cervical and lumbar adjustments, although these cases also have not been supported by the demonstration of causal relationship. We take care to screen each patient to determine which adjustment techniques would best suit them to achieve maximum benefit with minimized risk.

Chiropractic treatment and chiropractic adjustments have been the subject of many government reports and interdisciplinary studies conducted over the last 115 years, and have been demonstrated to be safe and effective. Chiropractic care contributes to your overall well being, and the risks of injuries or complications from chiropractic treatments is substantially lower than many other forms of treatment.

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 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 correspondence is often used in our office to communicate with patients as well as to send our free monthly wellness newsletter.

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

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

Patient Signature: _____
(or Legal Guardian if underage)

Signature of Witness:_____
(employee at Dynamic Balance Chiropractic)

Print Patient Name:_____

Print Witness Name:_____

Date:_____

Date:_____

Pregnancy History Questionnaire

Name:_____ Age: _____ DOB:_____ Today's Date:_____

1. If you are trying to become pregnant:
How many cycles have you been trying? _____ How long are your cycles? _____days
Are your cycles regular? Y / N
What, if any, has been your previous method of birth control?
□ None □ Birth Control Pill □ Condoms □ IUD □ Depo Provera shot □ Patch
□ Fertility Awareness Method/Natural Family Planning □ Rhythm method □ Withdrawal

Have you had any previous miscarriages? Y / N If yes, when: _____
Please list any supplements (prenatal vitamin, herbs etc) you are taking: _____
_____
Are you taking any medications? _____
_____
Are you seeing a fertility specialist? (name/address/phone) _____
_____
Are any other health professionals treating you for fertility?_____
_____
Have you had any fertility testing/procedures done?_____
_____

2. If you are currently pregnant or have recently been pregnant:

What is/was your estimated date of delivery? _____
How many weeks pregnant are you? _____wks What was the term of your pregnancy? _____wks
How many previous pregnancies have you had? _____
Do you have other children? Y / N How many?_____
How did you conceive this pregnancy? □ Natural □ Medical intervention (IUI, IVF, medications, etc.) _____
_____
Who is/was in charge of your care for this pregnancy? (name/ address/phone) _____
_____
Any other professional attendants?_____
How many ultrasounds have you had/having during this pregnancy?_____
Any other testing?_____

Throughout your pregnancy, have you had any of the following: (if yes, list details)
Falls? _____
Motor Vehicle Accident? _____
Near miss MVA? _____
High Blood Pressure? _____
Diabetes? _____
Anemia? _____
Morning Sickness? _____
Indigestion? _____
Seizures? _____
Swelling (hands/feet)?_____
Thyroid Problems? _____
Heart Problems?_____
Back Pain?_____

Bleeding from the vagina?_____
Were you hospitialized?_____
Been told your baby was in the breech position?_____
Any other illnesses?_____
Any other issues? _____

3. During your pregnancy, or while trying to conceive, did you use any of the following:

Tobacco? □ Never □ Occasionally _____ □ Daily _____packs/day
Alcohol? □ Never □ Occasionally _____ □ Daily _____drinks/day
Non-prescribed drugs? □ Never □ Occasionally _____ □ Daily _____/day
Prescription medications? □ Never □ Yes Medication:_____
Reason: _____
Over-the-counter meds? □ Never □ Yes Medication:_____
Reason:_____

Is there anything else that you think we should know about your pregnancy? _____
_____

For better co-management of your case, may we contact the health professionals working with you? □ Yes □ No
If yes, please list which ones: _____
_____

I certify that all above information is true, to the best of my knowledge.

Patient Signature: _____ Date:_____

Patient Name Printed: _____