Dynamic Balance Chiropractic
Adult 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_____
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_____
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: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____
5. _____ 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? _____
_____

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

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:_____
_____

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

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

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 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.

We do our very best to focus on your needs, and how to best deliver that. We partner with you in the aim of improved health and vitality, and reaching your goals. This is where we dedicate the fullest of our efforts. We do not therefor engage directly with third party payors, such as extended health benefits. 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 at or before the time that the services are performed.

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:_____