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Adult Health Questionnaire

Name ______________________________________M___/F___ Date____________________
Address _________________________ Unit #____City ______________Postal Code _____
H. Phone _______________W. Phone ______________ Cell Phone____________________
E-mail_____________________________ Date of Birth (dd/mm/yy)___________________
Can we contact you by e-mail_______ text message_______
Occupation _________________________Number of children and Ages________________
Have you seen a Chiropractor before? When?_____________________________________
Family Practitioner Name and Address____
Referred By____

About Your Health

You were born to be healthy! Unfortunately your health, your Innate Intelligence, can be interfered with. As Deepak Chopra M.D. has discovered, "All disease results from the disruption of the flow of intelligence." Chiropractic removes this interference when it happens in the spine (vertebral subluxations/VSC) so you can express your natural health potential throughout life!

1a. Is this a wellness check-up or do you have a specific health concern?
____
____

b. What is your major complaint? (Please describe)
____
____
____

c. Is the condition interfering with work? _____ Sleep? _____Hobbies? _____

d. Have you consulted anyone else for this condition?
____

e. Have you tried anything to get rid of this problem?
____
____

Name: ________________________

f. Other symptoms you have experienced in the last 6 months: (please circle)

Headaches	Pins & Needles Leg	Loss of smell
Neck	Pins & Needles Arm	Loss of taste
Sleeping Problems	Numbness in toes	Diarrhea
Back pain	Shortness of breath	Feet cold
Nervousness	Fatigue	Hands cold
Tension	Depression	Stomach upset
Irritability	Cold Sweats	Dizziness
Chest pain	Constipation	Ears ring
Loss of memory	Fever	Allergies
Loss of balance	Fainting	

2. **Birth Process (Your own)** (Please fill out to the best of your knowledge)

Was your delivery long? ____
Was your delivery difficult? ____
Forceps? ____
Caesarean? ____
Breach/ Cephalic? ____
Home birth? ____
Hospital birth? ____
Mother given drugs during delivery? __________________________________
Was labor induced? ____

3. **Growth & Development** (Where applicable, provide detail)

Were you breast-fed? ____
Childhood sickness? ____
Accidents? ____
Surgery? ____
Drugs? ____
Any Falls? ____
Did you have other traumas? What? When?_____________________________
____
____

Name: ________________________

4. **Current Health Habits**

Did / do you smoke? ____

Did/ do you drink alcohol? ____

Diet (do you eat healthy foods)? ______________________________________

Have you been involved in any car accidents? When?

____

Have you had any surgery or organs removed or replaced?

____

Drugs? (prescriptive or non-prescriptive)

____

Teeth problems? ____

Eye problems? ____

Hearing problems? ____

Physical exercise? ____

Sleeping habits (position)? ____

Did/ do you have occupational stress? _________________________________

Physical stress? ____

Mental stress? ____

Hobbies / Sports injuries? ____

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care,** which corrects the most recent layer of Spinal and Neurological damage (VSC).
This care usually reduces or eliminates the symptoms. **Reconstructive Care** begins after this and corrects the years of damage that have occurred**;** this will be explained at your report of findings. Then you will be able to begin a course of care that fits your health goals.

Examination Fees

	Cost
Consultation	----------Complimentary---------
Examination	$70.00
X-rays (if applicable)	$90.00

Consent to Examination and X-rays (if applicable)

Patient Signature (Legal Guardian) : ____________________________________

Date: ____

Date of last menstrual period? ______________________

Are you currently pregnant? Y/N ______________________

Name: ________________________

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits
Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back, and other areas of the body caused by nerves, muscles, joints and related issues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks
The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

Temporary worsening of symptoms- Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

Skin irritation or burn - Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

Rib fracture- While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

Injury or aggravation of a disc- Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment , like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

Stroke- Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was

progressing toward a stroke when the patient consulted the chiropractor. Present, medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

____

Name (Please Print)

____________________________________ Date: ________________ 20___

Signature of patient (or legal guardian)

____________________________________ Date: ________________ 20___

Signature of Chiropractor