



Chiropractic Health Questionnaire

Personal Information

Last Name: _____ First Name: _____ Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security #: _____

Home Phone: _____ Email address: _____

Work Phone #: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Work address: _____

City: _____ State: _____ Zip: _____

Sex Male Female Marital Status: Single Married Divorced Widowed

Spouses Name: _____ # of children: _____

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office?

Telephone call Yellow Pages Sign Website Presentation E-mail

Family member/Friend's name _____

Emergency Contact

Name: _____ Relation: _____

Home Phone #: _____ Work Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Major Complaint Information

What is your reason for contacting us? _____

When did this begin? _____ Yes No – Have you had this before?

What aggravates it? _____ What helps it? _____

Yes No – Does heat affect it? If so, how? _____

Yes No – Does cold affect it? If so, how? _____

Yes No – Does this condition interfere with your sleep? If so, how many times do you wake from pain per night? _____

Yes No – Do any other symptoms accompany this? Please list: _____

Yes No – Have you seen another Doctor for this? Doctors name and specialty: _____

_____ Date consulted: _____ Diagnosis: _____

Yes No – Have you experienced these symptoms before? When? _____

Did this develop from? an auto accident a work injury don't know (chronic) other

Yes No – If the doctor feels that chiropractic will help you, are you willing to follow his recommendations?

Welcome to our office! It is well known that families who maintain healthy, properly functioning spines have improved health and long lasting vitality. People whose spines are not functioning correctly are more likely to develop health disorders, immune compromise such as getting sick easier or allergies, pain, low energy, arthritis, and set themselves up for even worse health challenges.

Physical Health History

Height: _____ Current weight: _____ Yes No – Any recent weight changes?

Please list and describe any past injuries or accidents (including auto accidents, work and sport injuries, etc.)

When was your last spinal examination? _____ Never

How many times have you visited a chiropractor in your lifetime? _____ Never

Yes No – Have you ever been told that you have spinal curvature, spinal arthritis, or inherited spinal conditions?

Yes No – Spinal dysfunctions can cause decay and degeneration that result in grinding or cracking. Have you ever heard noises when you move your head or neck?

Poor posture leads to poor health and often indicates a spinal condition. How would you rate your posture? Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent

Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low – 1 2 3 4 5 6 7 8 9 10 – High

In what position do you sleep? Back Side Stomach

Yes No – Do you sleep with a pillow? How many pillows do you use? _____

Yes No Not sure – If female are you pregnant? If so, when is your due date: _____

Medical History

Surgeries None

Procedure _____ Date _____ Doctor/Hospital _____

Procedure _____ Date _____ Doctor/Hospital _____

Prescription medications may cause various side effects, hide the severity of health conditions and/or hinder the body's ability to heal. Please list all prescription and over-the-counter medications (including frequency and dosage) you have taken within 5 years:

What are your objectives/goals after you regain your health?

Who was the last doctor who put you on a total health development program?

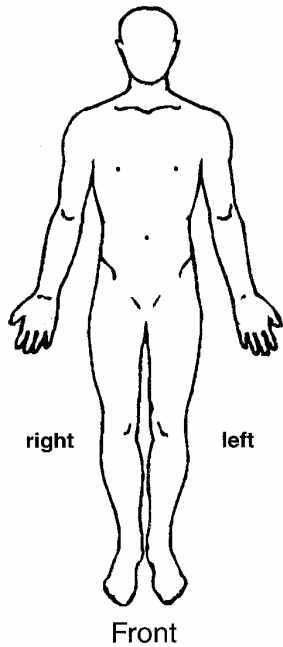
Yes No – Are you healthier than you were 5 years ago? If so, how did you achieve that?

Please list any additional health history / information that you may feel is important for the doctor to know before you begin care:

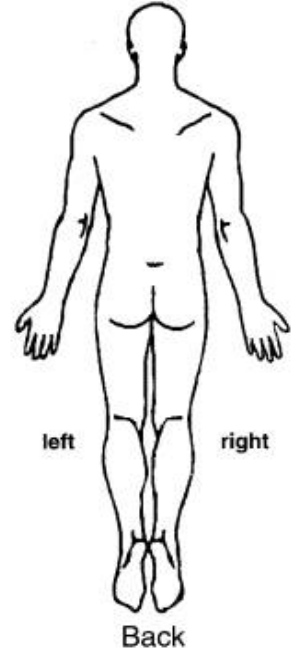
If there were an affordable way to correct your health problem, would you be willing to do what it takes to accomplish this now? Yes No

Is your spouse or sig. other supportive of your pursuit of health and wellness? Yes No

PLEASE MARK ANY AREAS WHERE SYMPTOMS ARE PRESENT AND DESCRIBE BELOW (type of pain [sharp, dull, achy, throbbing] and the intensity on a 1-10 scale when it is worst, i.e. sharp, shooting – 6):



Description: _____



Past Medical History

- | | | | |
|------------------------------|--|------------------------------|---|
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Alcoholism | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Jaw pain |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Anemia | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Kidney Disease |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Anorexia / Bulimia | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Liver disease |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Anxiety | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Loss of Balance |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Asthma | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Loss of Consciousness |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Arthritis | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Loss of Taste |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Bleeding disorder | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Memory loss |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Cancer | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Menopause |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Carpal Tunnel Syndrome | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Multiple Sclerosis |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Chemical Dependency | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Nail Changes |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Depression | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Osteoporosis |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Diabetes | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Premenstrual Syndrome |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Digestive troubles | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Ringing in ears |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Fatigue | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Shortness of Breath |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Headaches | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Sinus congestion |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Heart Disease | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Stroke |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – High Cholesterol | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Tumors / Growths |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – HIV Positive | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Ulcers |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Hypertension | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Vertigo |
| <input type="checkbox"/> Now | <input type="checkbox"/> Past – Irritable | <input type="checkbox"/> Now | <input type="checkbox"/> Past – Vertigo |

Yes No – Do you have or have you ever had any disease or medical problems not listed?

Please List below:

Signature

I certify that the above information is complete and correct to the best of my knowledge. I will not hold my doctor or any staff member of Arbor Lakes Chiropractic Center responsible for any inaccuracies, errors or omissions that I may have made in completing this form.

 Patient Signature

 Date

 Parent or Legal Guardian Signature

 Date

Financial Policy

PAYMENT FOR SERVICES

Payment is expected at the time of service or before. There are exceptions for patients on Personal Injury claims, patients under care for injuries sustained in a Motor Vehicle Accident, those under care for injuries sustained on the worksite or those circumstances approved by the Office Manager or Dr. Sullivan.

Any patient or third party not paying in full at the time of service is charged the usual and customary rate for service performed. Patients or third parties paying in full at the time of service qualify for a "time of service" (TOS) discount.

All patients and third party payers have the right to participate in our money saving pre-payment programs. These will be described further at your Solution Report.

INSURANCE

Our mission is to help get you well through a chiropractic lifestyle. To assist those also committed to this goal; we will help process and bill your insurance claim to help you receive the benefits to which you are entitled.

We work for you. Our recommendations for your treatment plan will be based solely on your chiropractic needs. Working for your insurance company would require us to treat you the way they dictated, with little to no regard for your actual chiropractic needs. Our responsibility is to you; if we let someone else make the decision on how you are going to be treated that would be a contradiction. Contradictions lead to destruction. In this case the destruction of the doctor-patient relationship and possibly the destruction of your opinion of the chiropractic profession. This is the primary reason we do not work for insurance companies or HMO plans.

This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

ETC.

In the event arrangements are made for chiropractic care to be provided before it has been paid, a valid credit card must be on file and the appropriate paperwork must be completed and on file to secure the account.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

I have read and understand Arbor Lakes Chiropractic Center's Financial Policy.

Signed _____ Date _____ / _____ / _____

Your Exam at ALCC

Dear Patient,

The following is a brief explanation of what you can expect during the early part of your experience at Arbor Lakes Chiropractic Center plus a few definitions that may help clarify how we will be of service to you. The methods we will use to help us discover that which has kept you from health (as defined above) are some of the most advanced in the profession. They are some of the most precise and reliable tools in chiropractic today.

- Kinesiology – The study of how your muscles work and how your joints move; particularly studying what slow, weak and excessively tight or slack muscles tell us about the cause of your ill-health.
- Surface Electromyography (SEMG) – A non-invasive test that monitors the tone of your muscular system by detecting electrical activity in muscles that are controlled unconsciously by your nervous system.

The application of kinesiology in a clinical setting allows your chiropractor to more fully answer questions concerning the root causes of your ill health. In any abnormal condition of the body, whether there are symptoms yet or not, there is always accompanying nerve interference and corresponding abnormal muscle response(s) and joint motion problem(s). These problems are "seen" during testing as muscles that are too slow, weak, tight, slack or joints that don't move normally.

In applying kinesiology clinically, your muscle system is like a computer monitor. By monitoring your muscle responses to the stresses you go through in your everyday life, we are better able to detect the real causes of why you are not entirely well.

As we observe your muscle and joint function, either through manual muscle testing or the computerized SEMG, we will begin to find out what is "wrong" with you. This information will guide us toward using Chiropractic care most effectively to set your body's innate wisdom free so that it may heal you naturally.

As a patient at Arbor Lakes Chiropractic Center, I agree that muscle testing has been explained to me.

Signed _____ Date _____ / _____ / _____