# Adult Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

| | | |
|---|---|---|
| First Name: | Last Name: | Date: |
| SS#: | DOB: | Sex: ◯ M ◯ F |
| Marital Status: | # of Children: | Occupation: |
| Street Address: | | Height: |
| City, State, Postal Code: | | Weight: |
| Email: | Cell Phone: | Other Phone: |
| Emergency Contact: | Emergency Relation: | Emergency Phone: |

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

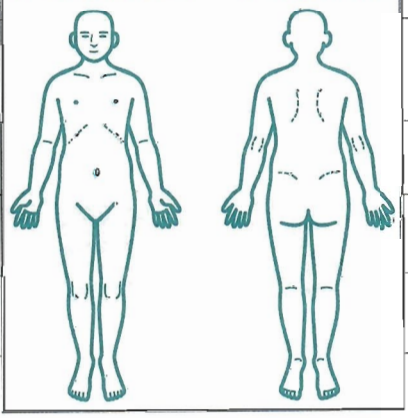
Are you also receiving care from any other health professionals? ◯ Yes ◯ No
- If yes, please name them and their specialty:

Please note any significant family medical history:

## CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.
X= Current condition O= Past condition



Have you received care for this problem before? ◯ Yes ◯ No
- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem better?

What makes the problem worse?

## YOUR HEALTH GOALS

Your top three health goals:

1. _____

2. _____

3. _____

## CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ Overall wellness ◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other: _____

Do you have any health concerns for other family members today?

## TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ◯ Yes ◯ No
- If yes, please explain:

Notable childhood injuries? ◯ Yes ◯ No If yes, please explain:

Youth or college sports? ◯ Yes ◯ No If yes, list major injuries:

Any auto accidents? ◯ Yes ◯ No If yes, please explain:

Exercise Frequency? ◯ None ◯ 1-3x per week ◯ 4-6x per week ◯ Daily
What types of exercise?

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach Do you wake up: ◯ Refreshed and ready ◯ Stiff and tired

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes per day?

List any problems with flexibility. *(ex. Putting on shoes/socks, etc.)*

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

## TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

| | *None* | | *Moderate* | | *High* | | *None* | | *Moderate* | | *High* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol | 1 | 2 | 3 | 4 | 5 | Processed Foods | 1 | 2 | 3 | 4 | 5 |
| Water | 1 | 2 | 3 | 4 | 5 | Artificial Sweeteners | 1 | 2 | 3 | 4 | 5 |
| Sugar | 1 | 2 | 3 | 4 | 5 | Sugary Drinks | 1 | 2 | 3 | 4 | 5 |
| Dairy | 1 | 2 | 3 | 4 | 5 | Cigarettes | 1 | 2 | 3 | 4 | 5 |
| Gluten | 1 | 2 | 3 | 4 | 5 | Recreational Drugs | 1 | 2 | 3 | 4 | 5 |

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

## THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

| | *None* | | *Moderate* | | *High* | | *None* | | *Moderate* | | *High* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Home | 1 | 2 | 3 | 4 | 5 | Money | 1 | 2 | 3 | 4 | 5 |
| Work | 1 | 2 | 3 | 4 | 5 | Health | 1 | 2 | 3 | 4 | 5 |
| Life | 1 | 2 | 3 | 4 | 5 | Family | 1 | 2 | 3 | 4 | 5 |

## ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: _____

## WERE YOU AWARE THAT...

| |
|---|
| DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ❑ YES ❑ NO |
| THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ❑ YES ❑ NO |
| CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO |

## GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ❑ **Relief care:** Symptomatic relief of pain or discomfort.
- ❑ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- ❑ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ❑ ***I want the Doctor to select the type of care appropriate for my condition.***

## MEDICATIONS YOU TAKE

| | |
|---|---|
| ❑ CHOLESTEROL MEDICATIONS | ❑ BLOOD PRESSURE MEDICINE |
| ❑ STIMULANTS | ❑ BLOOD THINNERS |
| ❑ TRANQUILIZERS | ❑ PAIN KILLERS (INCLUDING ASPIRIN) |
| ❑ MUSCLE RELAXERS | ❑ OTHER: |
| ❑ INSULIN | ❑ OTHER: |
| ❑ VITAMINS & SUPPLEMENTS: | |

## YOUR CONCERNS

***INSTRUCTIONS:*** *Please **circle** the health concerns or conditions you may be experiencing now or have in the past. Each area of concern relates to an area of the spine and nerve function.*

*Sore Throat*
*Stiff Neck*
*Radiating Arm Pain*
*Hand/Finger Numbness*
*Asthma*
*Allergies*
*High Blood Pressure*
*Heart Conditions*


*Headaches*
*Migraines*
*Dizziness*
*Sinus Problems*
*Allergies*
*Fatigue*
*Head Colds*
*Vision Problems*
*Difficulty Concentrating*
*Hearing Problems*

*Middle Back Pain*
*Congestion*
*Difficulty Breathing*
*Bronchitis*
*Pneumonia*
*Gallbladder Conditions*
*Stomach Problems*
*Ulcers*
*Gastritis*
*Kidney Problems*

*Constipation*
*Colitis*
*Diarrhea*
*Gas Pain*
*Irritable Bowel*
*Bladder Problems*
*Menstrual Problems*
*Low Back Pain*
*Pain or Numbness in legs*
*Reproductive Problems*

**OTHER:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

## HEALTH CONDITIONS

**INSTRUCTIONS:** *Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

| | | | | |
|---|---|---|---|---|
| ❑ SEVERE OR FREQUENT HEADACHES | ❑ THYROID PROBLEMS | ❑ PAIN IN ARMS/ LEGS/HANDS | ❑ NUMBNESS | FOR WOMEN ONLY: |
| ❑ HEART SURGERY/ PACEMAKER | ❑ SINUS PROBLEMS | ❑ LOW BLOOD PRESSURE | ❑ ALLERGIES | ARE YOU PREGNANT? ❑ YES ❑ NO |
| ❑ LOWER BACK PROBLEMS | ❑ HEPATITIS | ❑ RHEUMATIC FEVER | ❑ DIABETES | IF YES, WHEN IS YOUR DUE DATE? |
| ❑ DIGESTIVE PROBLEMS | ❑ DIFFICULTY BREATHING | ❑ ULCERS/COLITIS | ❑ SURGERIES: | ARE YOU NURSING? ❑ YES ❑ NO |
| ❑ PAIN BETWEEN SHOULDERS | ❑ KIDNEY PROBLEMS | ❑ TUBERCULOSIS | ❑ ASTHMA | ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO |
| ❑ CONGENITAL HEART DEFECT | ❑ HIGH BLOOD PRESSURE | ❑ ARTHRITIS | ❑ LOSS OF SLEEP | DO YOU: EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO |
| ❑ FREQUENT NECK PAIN | ❑ CHEMOTHERAPY | ❑ SHINGLES | ❑ DIZZINESS | HAVE IRREGULAR CYCLES? ❑ YES ❑ NO<br>HAVE BREAST IMPLANTS? ❑ YES ❑ NO |

## AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are on arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

| SIGNATURE: | DATE: |
|---|---|
| SIGNATURE OF GUARDIAN OR SPOUSE AUTHORIZING CARE: | DATE: |

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

☐PATIENT ☐SPOUSE ☐PARENT ☐WORKERS COMP ☐AUTO INSURANCE

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic care we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific adjustments to the spine.

**Health** is a state of optimal physical, mental and social wellbeing, not merely the absence of disease.

**Vertebral Subluxation** is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other then vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfactions. I therefore accept chiropractic care on this basis.

| SIGNATURE: | DATE: |
|---|---|
| WITNESS SIGNATURE: | DATE: |

## NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that under the *Health Insurance Portability & Accountability Act of 1996 (HIPPA)*, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician's certifications.

I have read and understand your *Notice of Privacy Practices*. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

| PATIENT NAME (PLEASE PRINT): | RELATIONSHIP TO PATIENT: |
|---|---|
| SIGNATURE: | DATE: |

# Body in Balance Wellness Center

Dr. Kimberly Guthrie and Dr. Jessica Hudson
Chiropractic Physicians
7360 SW Hunziker Rd, Suite 203
Tigard, OR. 97223
Phone: 503-675-8747 Fax: 503-699-9136

## OFFICE & FINANCIAL POLICIES

- Payment is expected at the time of service. We accept cash, check, Visa, Mastercard, Discover and Care Credit.
- You are responsible for timely payment on your account. Unpaid balances over 60 days may be charged 1.5% interest per month (18% annual) and/or subject to collection activity.
- Maximum allowable outstanding balance is $200.00 unless other arrangements have been made. You may be ineligible to receive further services until your balance is paid down.
- All supplements/vitamins, lab work, supports and other supplies must be paid for at the time they are received unless prior arrangements have been made.
- If you are late for your re-exam appointment, this may result in additional waiting time, and your scan may need to be rescheduled.
- If you have not had an adjustment in three months, you must have an exam prior to being adjusted.
- If you choose to discontinue care, you are required to have an exam before being released from care. If you choose to return, you must have an exam before your next adjustment.

**Motor Vehicle Accident, Personal Injury and Worker's Compensation Claims:**

- Cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out and a claim is filed. **If your claim is denied or reimbursement/compensation does not cover fees incurred, you are responsible for prompt payment of your account balance.**
- We do not do third party billings to other insurance companies for motor vehicle accident and personal injury cases.
- If you choose not to file a claim with your insurance company, or are uninsured, your account will be treated as a cash account and all fees will be due at the time of service.
- Lab work, supports and other supplies may not be covered by your insurance company. If your insurance company does not pay such items, then you are responsible for your bill.
- If you are late for your appointment, this may result in additional waiting time, an adjustment only, or your appointment may need to be rescheduled.
- Missed appointments may be subject to a $75.00 cancellation fee if we do not receive your cancellation at least 4 hours prior to your scheduled appointment. You are responsible for this fee and it must be paid in full prior to your next appointment.

**By signing below, you have read, understand and agree to the above office and financial policies.**

_____ _____

Patient Signature or Guardian Signature Date