

Adult Chiropractic Health Questionnaire

Welcome to Wellness Rhythms!
"there's freedom in a healthy spine"

Name _____ Home Phone _____
Address _____ Work Phone _____
City, State, Zip _____ Cell Phone _____
E-mail Address _____
Birth date _____ Age _____
Occupation _____ Employer _____
Status: Married Widowed Separated Divorced Single Spouse Name _____ No. of Children _____

Please answer the following questions:

- Spinal problems can cause a variety of health problems. Please check the health complaint(s) you are currently experiencing or experience on a periodic basis:

<input type="radio"/> Low Back Pain	<input type="radio"/> Arm or Hand Pain	<input type="radio"/> Carpal Tunnel Syndrome	<input type="radio"/> Indigestion
<input type="radio"/> Upper/Mid Back Pain	<input type="radio"/> Leg or Foot Pain	<input type="radio"/> Ear Infections	<input type="radio"/> Chronic Fatigue
<input type="radio"/> Neck Pain	<input type="radio"/> Asthma	<input type="radio"/> Frequent Colds	<input type="radio"/> Arthritis
<input type="radio"/> Shoulder Pain	<input type="radio"/> Allergies/Sinus	<input type="radio"/> Spinal Curvature	<input type="radio"/> Fibromyalgia
<input type="radio"/> Others _____			
- What is your primary health complaint? _____
- Auto and work injuries can cause serious spinal problems. Is this visit related to an auto or work injury? Yes No
- When was your last complete chiropractic examination including x-rays?
 within the last year 1 - 5 years 5 years or longer Never
- Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
 YES NO If yes, circle one
- Long term spinal misalignments can cause decay and arthritis in the spine which may result in grinding or popping noises. Do you ever hear grinding or popping noises when you move your head or neck? YES NO
- Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to twist, stretch or crack your neck, mid or lower spine? YES NO
- Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your posture?
Poor - 1 2 3 4 5 6 7 8 9 10 - Very Good
- Stress can cause or aggravate spinal problems. Please rate your stress levels over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High
- Are you currently taking prescription medication? YES NO If so, how many? _____
- Spinal health is especially important during pregnancy. If female, is there any chance that you are pregnant?
 YES NO MAYBE If yes, when is your due date? _____ or Date of Last Cycle? _____
- Have you ever been diagnosed with cancer? YES NO If so, what kind? _____ Year diagnosed _____
- Have you ever had spinal surgery? YES NO If yes, where? _____
- If the doctor feels that you will benefit from chiropractic care, are you willing to follow his/her recommendations?
 YES NO _____
- How will you be paying for today's visit? Credit/Debit Card Cash Check Other _____
- Most patients are referred to our office by a caring family member or friend. Why did you decide to visit our office?

Friend/Family Member Name: _____
(please circle) Telephone Sign Website Presentation Screening Email Other _____

Please continue to page 2...

HISTORY OF PHYSICAL STRESS Check all that apply and note dates:

BIRTH Were there any problems associated with your mother's pregnancy with you? (Check all that apply)

- falls/injury illness difficult other _____

Was your birth: (check all that apply)

- drug induced C section breech natural forceps/suction
 prolonged cord around neck home hospital traumatic

Comments or additional information: _____

GENERAL PHYSICAL TRAUMA: Have you had an accident/near accident, even as a passenger, in a(n): (check all that apply)

- automobile motorcycle bus train bicycle plane other _____

Explain with Dates: _____

Medical interventions: (check all that apply)

- hospitalization surgery chemotherapy casts/collars traction braces
 shoe lifts etc. physiotherapy spinal tap x-ray therapy transfusion other
 organ removal acupuncture extensive X-rays

Comments: _____

- FALLS: from crib ____ tree ____ bicycle ____ steps ____ skates ____ on ice ____
 physical fight ____ armed forces ____ abuse ____ unconscious ____
 used crutch/cane ____ broken nose ____ major dental work ____ childhood illness

Please describe daily activities for work, home or school such as sitting, lifting, standing, phone work, sports, exercise, etc.: _____

HISTORY OF CHEMICAL STRESS Please check all that apply:

During your mother's pregnancy did she: (check all that apply):

- use prescription drugs use non-prescription drugs chemically induce birth consume alcohol smoke unknown

Comments: _____

Have you and your family members been vaccinated? Y N

Do you or have you ever taken: prescription drugs over the counter drugs antibiotics other

Do you or have you ever worked with: chemicals fumes dust smoke

Do you consume: alcohol coffee/caffeine tobacco tap water

recreational drugs artificial sweeteners refined sugar meat other

Comments: _____

Please describe your eating habits: _____

HISTORY OF EMOTIONAL STRESS: Emotional and Mental stress can cause and/or accelerate spinal and nerve dysfunction.

How do you grade your physical health? Excellent Good Fair Poor Getting Better Getting worse

How do you grade your emotional/mental health? Excellent Good Fair Poor Getting Better Getting worse

How do you rate your overall quality of life? Excellent Good Fair Poor Getting Better Getting worse

Please check all that apply and note their severity on a 1-5 scale (1 is the easiest and 5 the most difficult).

- Childhood ____ Loss of loved one ____ Recreation ____ Family ____ Work ____
 Stress of illness ____ Relationships ____ Commuting ____ School ____ Abuse ____
 Divorce/separation ____ Parents divorce ____ Financial ____ Lifestyle change ____ other ____

Comments: _____

Which are you most interested in? Crisis and emergency care Wellness and maintenance care

Have you ever or do you currently receive the following vehicles toward growth, healing or personal development?

- Chiropractic Somato-respiratory integration Bodywork Massage
 Osteopathy Meditation Psychotherapy Movement or exercise
 Prayer Rebirthing Reiki other _____

Is there anything else you may wish to share which may help us to better understand you, and why you have chosen to come to this office? _____

In Network care people report changes in their physical state, mental emotional states, their body's ability to adapt to stresses, achieve a heightened quality of life and make positive lifestyle choices. Which of these would most excite you to share Network Care with your friends and family? _____

The above information is true and accurate to the best of my knowledge. By signing this form, you are granting Wellness Rhythms, and its representatives permission to contact you by phone, email and/or US Mail. I also consent to a chiropractic examination.

Signature _____ Today's Date _____

Name: _____ Date: _____

REVIEW OF SYSTEMS- Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less than optimal function.

Check either **I DENY having/had** OR **Circle P for PAST** OR **Circle N for NOW**

CONSTITUTIONAL

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** chills
- P N** daytime drowsiness
- P N** fatigue
- P N** fever
- P N** night sweats
- P N** weight gain
- P N** weight loss

EYES

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Wear glasses or contact lenses
- P N** blindness
- P N** Cataracts
- P N** Glaucoma

EARS / NOSE / THROAT

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Difficulty/Loss of hearing
- P N** Ringing in the ears (tinnitus)
- P N** Frequent ear aches
- P N** Discharge from the ear
- P N** Attacks of vertigo
- P N** Sinus trouble
- P N** Nasal blockage
- P N** Frequent sneezing
- P N** Frequent sore throat
- P N** Snoring
- P N** Recent change in voice quality
- P N** Sleep apnea
- P N** Difficulty in swallowing
- P N** Nose bleeds

RESPIRATORY

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Asthma or wheezing
- P N** Recent bronchitis or chest cold
- P N** Cough
- P N** Coughing up blood
- P N** Shortness of breath

HEART & CIRCULATION

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Heart attack
- P N** High blood pressure
- P N** Heart murmur
- P N** Chest discomfort (angina)
- P N** Heart failure or fluid on the lungs
- P N** Palpitations, racing or pounding
- P N** Shortness of breath w/activity
- P N** Stroke / mini stroke or TIA

- P N** Blood clot in artery or vein
- P N** "Black out spells"
- P N** Aneurysm of any blood vessel
- P N** Swelling of legs
- P N** Heart surgery
- P N** Heart palpitations

STOMACH / INTESTINES

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Ulcer
- P N** Frequent heartburn or indigestion
- P N** Hiatal hernia and or acid reflux
- P N** Poor appetite
- P N** Gall bladder attacks
- P N** Frequent diarrhea
- P N** Chronic constipation
- P N** Bright blood bowels or rectum
- P N** Abnormal stool
- P N** Liver disease or jaundice

ENDOCRINE / METABOLISM

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Thyroid disorder
- P N** Unusual hair loss or growth
- P N** goiter
- P N** Diabetes

KIDNEYS / URINARY TRACT

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Kidney disease or failure
- P N** History of kidney dialysis
- P N** Kidney stones or infection
- P N** Pain or burning with urination
- P N** Trouble starting urinary stream
- P N** Dribbling or incontinence
- P N** Frequent Night Urination
- P N** Bladder infections during past year
- P N** Blood in urine during past year

MUSCLES / BONES / JOINTS

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Arthritis or other joint disease
- P N** Chronic back trouble
- P N** Bone or joint surgery in past year

ALLERGY

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** anaphylaxis
- P N** food intolerance
- P N** itching
- P N** nasal congestion
- P N** rash
- P N** sneezing

SKIN

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Rashes, psoriasis or dermatitis
- P N** History of skin cancer
- P N** New skin growth or mole

NERVOUS SYSTEM

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Headache
- P N** Epilepsy or seizures
- P N** Date of last seizure: _____
- P N** Depression
- P N** Other nervous disorder

Specify: _____

PSYCHOLOGIC

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** anxiety
- P N** loss or change in appetite
- P N** behavioral change
- P N** bi-polar disorder
- P N** confusion
- P N** convulsions
- P N** depression
- P N** insomnia
- P N** memory loss
- P N** mood change

BLOOD

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Bleeding or bruising tendency
- P N** Previous blood transfusion
- P N** History of hepatitis

MEN ONLY

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Testicular swelling
- P N** Prostate Problems
- P N** Frequent urination

WOMEN ONLY

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Painful periods
- P N** Excessive Flow
- P N** Irregular cycles
- P N** Vaginal Burning
- P N** Hot Flash

Are you pregnant? Yes No

Past Medical and Family History

Surgical History: (NONE) _____

Hospitalization History: (NONE) _____

Allergy History: (NONE) _____

Please circle the following diseases if your family members (blood relatives) have experienced them:

Diabetes Cancer High Blood Pressure Allergy Hearing Loss Stroke Bleeding Disorder

List any other illness that "runs in your family" (blood relatives): _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ PULSE _____ N/A MINOR

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature: _____

Date: _____

Those in **Network Care** have reported improvement in the following areas. Please check the areas in which you have an interest in improving. Name _____

Improved Physical State relative to:

- Less physical pain
- Less tension or stiffness of spine
- Improved posture
- Feeling more grounded and connected to body
- Feeling more flexible
- Less tension/stress in body
- Improved, fuller breath
- More energy
- Connection to body
- Trusting body

Improved Mental/Emotional State relative to:

- Improved positive feelings about self
- Less moodiness and/or angry outbursts
- Depression
- Anxiety
- Being less reactive to others
- More interest in life
- Improved ability to think and concentrate
- Less anxiety and concern about vague fears
- Improved ability to stay on task
- Less distress about pain
- Connection to self and others
- Less mind chatter
- Fears
- Letting go of past traumas
- Wider range of emotion
- Moving out of fight or flight

Improved Response to Stress:

Less stress relative to:

- Family
- Significant relationship
- Health
- Finances
- Daily problems
- Work
- General well being

Improved Life Enjoyment relative to:

- Openness to guidance by “inner voice feelings”
- Experience of relaxation and wellbeing
- Positive feelings about self
- Interest in maintaining a healthy lifestyle
- Feeling open when relating to others

Improved Life Enjoyment relative to:

- Confidence when dealing with adversity
- Compassion for and acceptance of others
- Compassion for self
- Incidence of feelings of joy or happiness
- Feeling connected to self
- Feeling connected to others
- Wellness

Improved Overall Quality of Life relative to:

- Personal life
- Extent one adapts to change
- Handling of problems in life
- Actual life accomplishments
- Life as a whole
- Overall contentment with life
- Significant other
- Job Life being what one wants it to be
- Romantic life
- Actual work done
- Co-workers
- Physical appearance
- Increase of health promoting practices
- Decrease of health detracting practices
- Transformation
- Spiritual Journey

Please place a star by your top three choices.