

UPPER CERVICAL
CHIROPRACTIC
OF BEMIDJI

ADULT PATIENT
Questionnaire

Today's date: _____ Referred by: _____

CONFIDENTIAL PATIENT INFORMATION

Legal First Name: _____ Last Name: _____ DOB: ____ / ____ / _____

Preferred Name: _____ Preferred Pronoun: She He _____ Gender: _____

Relationship Status: _____ Children: _____ Occupation: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Email: _____ Phone: _____ How did you hear about us? _____

Would you like appointment reminders: Text message Email No **Emergency Contact:** _____

Phone carrier: _____ **Emergency Phone:** _____

Are you also receiving care from any other health professionals? Yes No

- If yes, please name them and their specialty: _____

Previous Chiropractor: _____ City: _____ State: _____

Last visit to this Chiropractor: _____ Reason for visit: _____

Reason for leaving: _____

FOR WOMEN ONLY

Are you currently pregnant? Yes No If yes, estimated due date: ____ / ____ / _____

Where do you plan to deliver? _____

Number of Prior Pregnancies: _____ Number of Births: _____ Are you currently breast feeding? Yes No

Date of your last menstrual period: ____ / ____ / _____ Are you and your partner trying to conceive? Yes No

Are you using any means of contraception? Yes No Do you experience severe cramping with your menstrual period? Yes No

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

CURRENT HEALTH

What health concern brings you into our office?

Have you received care for this concern before? Yes No

- If yes, please explain: _____

When did the concern(s) first begin? _____

How did the concern start? Suddenly Gradually Post-Injury

Is this concern: Getting worse Improving Intermittent Constant I'm not sure

What makes the concern better? _____

What makes the concern worse? _____

How does this concern interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this concern: _____

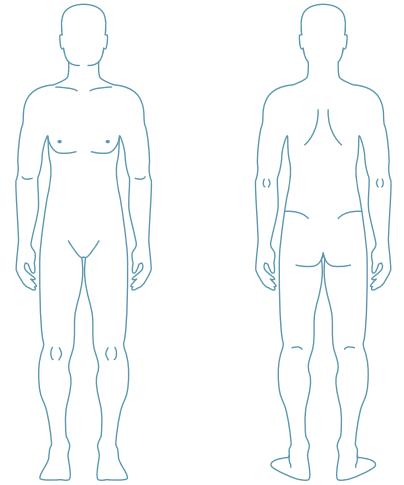
List any other doctors seen, treatments and results obtained: _____

List any current physician(s)/ therapist(s): _____

List any and all medications you are taking: _____

List your current other health concerns: _____

Please indicate where you're experiencing pain or discomfort.



WHAT CAUSES *subluxations*?

To help the doctor understand your situation better, what are some of the things in your life that may be causing subluxation in your spine on an ongoing basis?

Trauma PHYSICAL STRESS

- Accidents and falls
- Birth
- Bad habits (crossing your legs, sleeping on your stomach, wearing your purse on the same side, sitting all day, frequent texting, etc.)
- _____

Toxins CHEMICAL STRESS

- Poor diet (high sugar, GMOs, artificial additives)
- Medications, antibiotics, vaccines
- Environmental toxins (air pollution, cleaning supplies, tap water, etc.)
- _____

Thoughts EMOTIONAL STRESS

- Fear and anxiety
- Busy lifestyle
- Technology overload
- Social challenges
- _____

Please explain: _____

FAMILY HISTORY

List your family's health and medical history, past and current:

Do you have any children? Yes No

Do they have any health concerns that you are aware of?

HEALTH HISTORY

List all surgeries you have had and their dates: _____

Have you been involved in any car accidents? Yes No

- If yes, how many car accidents have you been involved in? _____

Car Accident #1

Date: ____ / ____ / _____

Driver Passenger

Speed of Accident: _____ mph

Describe the accident: _____

Were you injured in the accident? Yes No

If yes, list all injuries: _____

Did you receive/seek treatment for injuries listed above? Yes No

- If yes, what type? Was an ambulance called?

Are the injuries resolved? Yes No

Car Accident #2

Date: ____ / ____ / _____

Driver Passenger

Speed of Accident: _____ mph

Describe the accident: _____

Were you injured in the accident? Yes No

If yes, list all injuries: _____

Did you receive/seek treatment for injuries listed above? Yes No

- If yes, what type? Was an ambulance called?

Are the injuries resolved? Yes No

List any other traumas (e.g. accidents and falls, birth, bad habits like crossing your legs, sleeping on your stomach, wearing your purse on the same side, sitting all day, frequent texting, etc.) and their dates, if applicable:

Trauma #1: _____ Date: ____ / ____ / _____

Trauma #2: _____ Date: ____ / ____ / _____

Trauma #3: _____ Date: ____ / ____ / _____