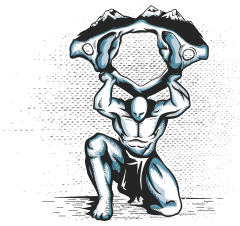


UPPER CERVICAL CHIROPRACTIC OF BEMIDJI

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

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

Email address for reminders: _____ **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

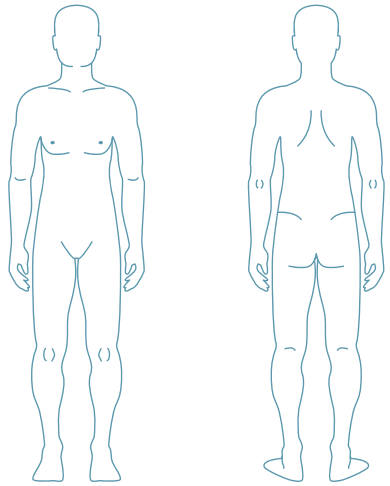
What makes the concern better? _____

What makes the concern worse? _____

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

WORK: _____

Please indicate where you're experiencing pain or discomfort.



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: _____

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
- ☐ T echnology 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: ___ / ___ / _____