Antler Point Chiropractic
Chiropractic Questionnaire
Patient Information

Name_____ Date_____

Address_____ City_____ State___ Zip Code_____

Home Phone_____ Cell Phone_____

Email Adress_____

Would you like to receive our newsletter and events through email? Yes No

Social Security_____ Date of Birth_____

How were you referred to our office? _____

Primary Physician _____ Phone Number _____

Do we have permission to contact your primary physician about your care here? Yes No

Current Employer_____ Telephone number _____

Employment status: Part Time Full Time Other

Emergency Contact & Relationship_____ Phone #_____

Health Insurance Information

Primary Insurance_____ ID#_____

Insured Persons name_____ Date of Birth_____

Secondary Insurance_____ ID#_____

Who is responsible for your Bill? You You and Spouse Workers Comp Auto Insurance

If your visit is related to an auto accident or work related injury:

Auto or Worker's Comp Insurance Company:_____

Date of accident or injury:_____ Claim #:_____

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What is your Major Symptom? _____

When is the 1st time you noticed the problem? _____

How did the injury occur? _____

Has it worsened? Yes No Same Unsure

How would you rate your pain? 1 2 3 4 5 6 7 8 9 10 (10 being worst)

How frequently does the pain occur? Constant Daily Comes & Goes Night Time

How long does the pain last? All Day ___ Hours ___ Minutes ___Seconds

When is the pain the worst? Upon Waking Evening As the day progresses No Change

Are there any health conditions that may be associated with your major symptoms?

_____

Describe the pain: Sharp Dull Numb Tingling Aching Burning Stabbing Throbbing

Other: _____

Does anything alleviate symptoms? Yes No Explain_____

What makes symptoms worse? Standing Sitting Lying Bending Lifting Twisting Reaching Extending Standing from Sitting Other_____

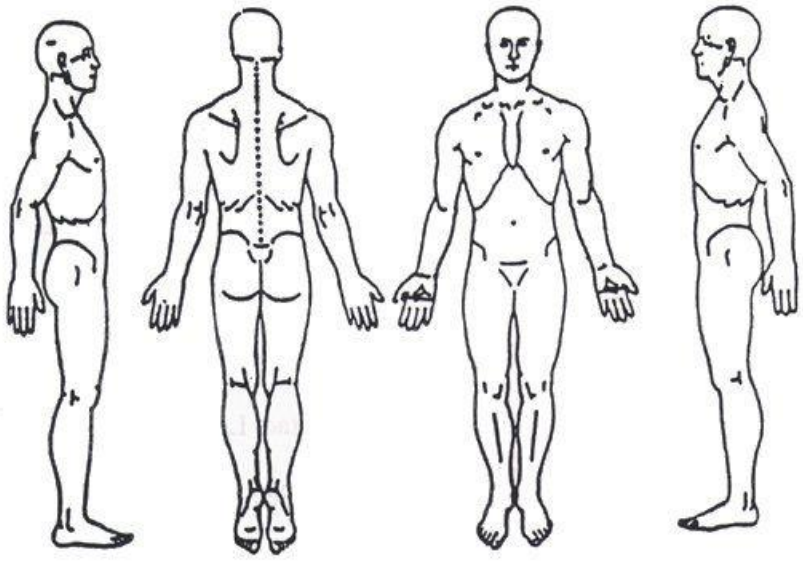
Secondary Symptom? _____

When did your 1st notice? _____How did the injury occur?_____

How would you rate your pain? 1 2 3 4 5 6 7 8 9 10 (10 being worst)

How frequently does the pain occur? Constant Daily Comes & Goes Night Time

Please indicate where you are experiencing pain:



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Personal Health History		
List any medical Problems that other doctors have diagnosed:		
☐Hypertension ☐Heart Disease ☐Stroke ☐ High Cholesterol ☐Kidney Disease ☐Diabetes ☐Chronic Back Pain ☐ Arthritis ☐Sciatica ☐Cancer ☐Depression ☐Dementia ☐Multiple Sclerosis ☐Fibromyalgia		
List of Prescription and over the counter medicatins		
Name of Drug	Strength	Frequency Taken
Surgeries		
Year	Reason	Hospital
Hospitalizations		
Year	Reason	Hospital
Past Tests:	☐Blood Work ☐ CT Scan ☐ MRI ☐ X-Rays ☐ Biopsy ☐Ultrasound ☐Cardio Echogram ☐EMG	
Date of Last Physical:		

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Family Health History					
Relative	Age	Health Problems/Cause of Death	Relative	Age	Health Problems/Cause of Death
Father			Child	M F	
Mother			Child	M F	
Sibling	M F		Maternal Grandmother		
Sibling	M F		Maternal Grandfather		
Sibling	M F		Paternal Grandmother		
Sibling	M F		Paternal Grandfather		

Review of Systems	
General	☐ Fatigue ☐ Allergies ☐ Loss of Sleep ☐ Fever ☐ Headaches
Musculoskeletal	☐ Low Back pain ☐ Pain Between Shoulders ☐ Neck Pain ☐ Arm Pain ☐ Joint Pain/Stiffness ☐ Balance Problems ☐ Difficulty chewing/Clicking ☐ Jaw ☐ General Stiffness
Nervous System	☐ Numbness ☐ Tingling ☐ Dizziness ☐ Fainting ☐ Seizures ☐ Confusion ☐ Cold/Tingling Extremities ☐ Vertigo
Gastro-Intestinal System	☐ Poor/Excessive Appetite ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Abdominal Pain ☐ Diarrhea ☐ Hemorrhoids ☐ Liver Problems ☐ Gall ☐ Bladder Problems ☐ Gas/Bloating ☐ Heart Burn ☐ Black/Bloody Stool
Respiratory/Cardiac	☐ Chest Pain ☐ Shortness of Breath ☐ High Blood Pressure ☐ Stroke ☐ Irregular Heart Beat ☐ Heart Problems ☐ Persistent Cough ☐ Wheezing ☐ Swelling in Legs ☐ Leg Cramps ☐ Varicose Veins
Genito-Urinary	☐ Bladder Trouble ☐ Painful Urination ☐ Discolored Urine
Endocrine	☐ Increased Thirst ☐ Increased Urination ☐ Thyroid Problems ☐ Diabetes
Eyes, Ears, Nose, Throat	☐ Vision Problems ☐ Tearing ☐ Sore Throat ☐ Ear Aches ☐ ☐ Ringing in ears ☐ Hearing Difficulty ☐ Sinus Pain ☐ Nasal ☐ Congestion

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to move joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, myofascial release, or cupping may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bones, muscular strains, ligament sprains, dislocations of joints, or injury to intervertebral discs, nerves, or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injuries to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few treatments. Ancillary treatment could produce skin irritation, burns, bruising, or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”. About as often as complications are seen from taking a single aspirin tablet. Cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered include the following:

- Over the counter analgesic. The risks of these medications include irritations to stomach, liver, and kidneys.
- Medically prescribed anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Remaining untreated: Delay of treatment allows formation of adhesions, scare tissues, and other changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable the delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the risks of treatment of my case explained to me. I have read and received explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have evaluated the risks and the benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	Signature	Date

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Dear Patient,

Beginning on April 14, 2003, healthcare facilities are required by the Federal Government to comply with the **Healthcare Insurance Portability and Accountability Act.** This program is to protect the way your health records are stored and conveyed and dictates to whom they are revealed.

The "Notice of Privacy Practices" describes how medical information about you may be used, disclosed, and will utilized by our office. We will attempt to answer or clarify any questions or concerns that you may have, or we will put you in contact with someone who can answer your questions.

Rest assured that your privacy is and always has been a very high priority with our office. We will continue to treat you with the privacy and dignity that you deserve.

By signing below, I acknowledge that I have reviewed this notice and all my questions have been answered to my satisfaction in language that I can understand.

I give the authority to release my health and/or account information to the following individual(s)

_____

(Name and Relationship to you)

_____ _____

Print Name Signature

_____ _____

Signature of Legal Representative Relationship

Date Signed:_____