Adult Patient Questionnaire

The Wellness Path
CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
SS#: - -	DOB: / /	Sex: M F
Marital Status:	# of Children:	Occupation:
Street Address:		Height: ft in
City:	State: Zip:	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?

Have you received care for this problem before? YES NO
-If yes, please explain:

When did the condition first begin?

How did this problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition: ☐ Getting Worse. ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

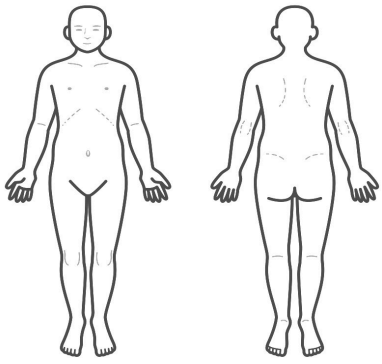
What makes the problem better?

What makes the problem worse?

How would you rate your pain/discomfort (0 = no pain, 10 need to go to emergency room):

Please indicate where you are experiencing pain/discomfort

X = Current Condition O = Past Condition



YOUR HEALTH GOALS

Your Top Three Health Goals?	Do You Have Any Root Canals? ☐ YES ☐ NO
1	If yes, how many?
2	Additional Health Goals?
3	

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ☐ Resolve Existing Condition ☐ 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-Base ☐ 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, please explain:

Any auto accidents? ☐ YES ☐ NO If yes, please explain:

Exercise Frequency? ☐ None ☐ 1-2x per week ☐ 3-5x per week ☐ Daily
What type of exercise?

How do you normally sleep? ☐ Back ☐ Side ☐ Stomach Do you wake up: ☐ Refreshed and Ready ☐ Stiff & 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 spend sitting at a desk or on a computer, tablet, or phone?

TOXINS: Chemical and Environmental Exposure

Please	rate your CONSUMPTION for each:										
	NONE		MODERATE		HIGH		NONE		MODERATE		HIGH
Alcohol	☐	☐	☐	☐	☐	Processed Foods	☐	☐	☐	☐	☐
Water	☐	☐	☐	☐	☐	Artificial Sweeteners	☐	☐	☐	☐	☐
Sugar	☐	☐	☐	☐	☐	Sugary Drinks	☐	☐	☐	☐	☐
Dairy	☐	☐	☐	☐	☐	Cigarettes	☐	☐	☐	☐	☐
Gluten	☐	☐	☐	☐	☐	Recreational Drugs	☐	☐	☐	☐	☐

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

THOUGHTS: Emotional Stresses and Challenges

	NONE		MODERATE		HIGH		NONE		MODERATE		HIGH
Home	☐	☐	☐	☐	☐	Money	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐	Health	☐	☐	☐	☐	☐
Life	☐	☐	☐	☐	☐	Family	☐	☐	☐	☐	☐

ACKNOWLEDGEMENT AND CONSENT

Patient Name: _____ Date: ___/___/_____

Fertility Questionnaire

The Wellness Path
CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT INFORMATION

When did you start actively trying to conceive a baby?

Have you ever become pregnant? ☐ YES ☐ NO

If yes, how many times?

Have you ever experienced a miscarriage? ☐ YES ☐ NO

If yes, how many and what week at your pregnancy did it occur?

When was your last period?

How are your menstrual cycles? (check all that may apply)

☐ Regular ☐ Irregular ☐ Painful ☐ Not Painful ☐ Cramping ☐ Bloating

How long is a typical cycle? _____ days

How long is a typical bleed? _____ days

Do you ovulate? ☐ YES ☐ NO
If yes, how do you test and know?

What supplement and/or medications are you taking?

Have you used any of the following fertility methods/drugs? (please check all that may apply)
☐ IVF ☐ IUI ☐ Clomid ☐ Ovidrel ☐ Other:_____

BIRTH CONTROL HISTORY

Have you ever been on birth control? ☐ YES ☐ NO What age did you start?

If yes, how many years in total have you been on birth control?

Reason for starting birth control?

What type of birth control have you been on? (check all that may apply)
☐ Pill ☐ Shot ☐ Ring ☐ Other:_____

How would you rate your pain/discomfort (0 = no pain, 10 need to go to emergency room):

I certify that the above information is true and correct to the best of my knowledge. As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility.

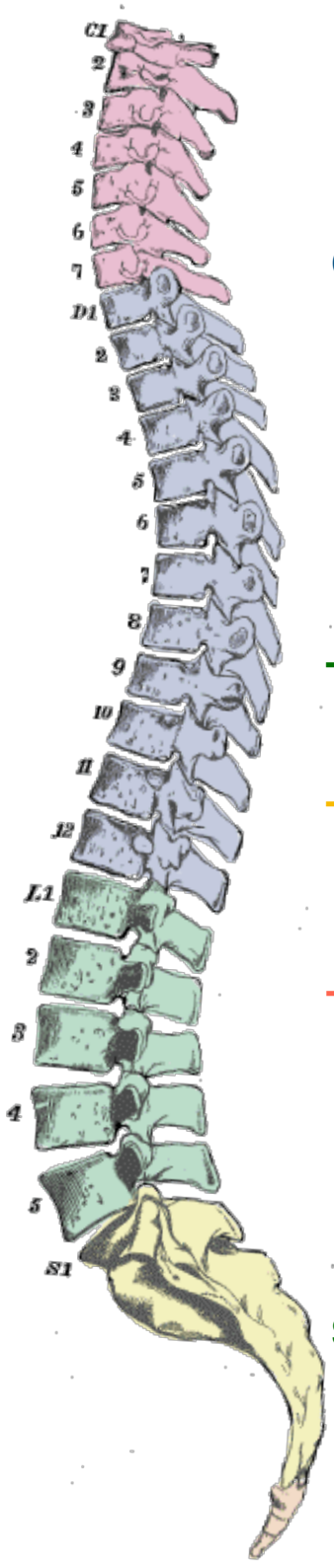
Patient Printed Name: _____

Patient Signature: _____ Date: ___/___/_____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS (Past / Present)	
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance and Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms and Hands • Sympathetic Nucleus • Metabolism	☐ ☐ Colic & Excessive Crying ☐ ☐ Ear & Sins Infections ☐ ☐ Allergies & Congestion ☐ ☐ Immune Deficiency ☐ ☐ Headaches & Migraines ☐ ☐ Vertigo & Dizziness ☐ ☐ Sore Throat & Strep ☐ ☐ Swollen Tonsils & Adenoids ☐ ☐ Vision & Hearing Issues ☐ ☐ Low Energy & Fatigue ☐ ☐ Difficulty Sleeping ☐ ☐ Pain, Numbness, & Tingling in Arms to Hands	☐ ☐ Epilepsy & Seizures ☐ ☐ Sensory & Spectrum ☐ ☐ ADD/ADHD ☐ ☐ Focus & Memory Issues ☐ ☐ Anxiety & Stress ☐ ☐ Balance & Coordination ☐ ☐ Speech Issues ☐ ☐ TMJ / Jaw Pain ☐ ☐ Stiff Neck & Shoulders ☐ ☐ Depression ☐ ☐ High Blood Pressure ☐ ☐ Poor Metabolism and Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐ ☐ Reflux/GERD ☐ ☐ Chronic Colds/Cough ☐ ☐ Asthma	☐ ☐ Bronchitis & Pneumonia ☐ ☐ Functional Heart Conditions
Upper Thoracic	• Major Digestive Center • Detox & Immunity	☐ ☐ Gallbladder Pain/Issues ☐ ☐ Jaundice ☐ ☐ Fever	☐ ☐ Indigestion & Heartburn ☐ ☐ Stomach Pains/Ulcers ☐ ☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐ ☐ Behavior Issues ☐ ☐ Hyperactivity ☐ ☐ Chronic Fatigue ☐ ☐ Chronic Stress	☐ ☐ Allergies & Eczema ☐ ☐ Skin Conditions/Rash ☐ ☐ Kidney Problems ☐ ☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐ ☐ Constipation ☐ ☐ Crohn's Colitis & IBS ☐ ☐ Diarrhea ☐ ☐ Bed-Wetting ☐ ☐ Bladder & Urination Issues ☐ ☐ Cramps & Menstrual Issues ☐ ☐ Cysts & Endometriosis ☐ ☐ Infertility ☐ ☐ Impotency ☐ ☐ Hemorrhoids	☐ ☐ Sciatica & Radiating Pain ☐ ☐ Lumbar/SI Joint Pain ☐ ☐ Hamstring Tightness ☐ ☐ Disc Degeneration ☐ ☐ Leg Weakness & Cramps ☐ ☐ Poor Circulation/Cold Feet ☐ ☐ Knee, Ankle & Foot Pain ☐ ☐ Weak Ankles & Arches ☐ ☐ Lower Back Pain ☐ ☐ Gluten & Casein Intolerance

Name: _____ **Date:** _____/_____/_____

Name: Date:

	Statement In the last 30 days, have you:	Did not apply to me at all	Applied to me to some degree or some of the time	Applied to me a considerable degree or a good part of the time	Applied to me very much or most of the time
1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feelings	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

The Wellness Path
CHIROPRACTIC CENTER

320 W. Burlington Ave., La Grange, IL 60525
708.497.2441
info@VisitTheWellnessPath.com
ww.VisitTheWellnessPath.com

INFORM CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases

of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE PREMIER WELLNESS CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED THIS ____ DAY OF _____, 20___

_____ _____

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____
Remarks:

The Wellness Path

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Duty

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Uses and Disclosures

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. Example: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. Example: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. Example: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. Example: Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards, text messages or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization:**

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health- related benefits and services that may be of interest to you. You should be aware that we utilize an “open adjusting room” in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your

protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY TIME. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health- record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Patient Rights

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request. We are obligated to notify you if there is a breach of your PHI unless there is a low probability of PHI compromise.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer, The Wellness Path, 320 W. Burlington Ave., La Grange, IL 60525

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

_____ _____

Patient Name Patient Signature

_____ _____

Name of Personal Representative Signature of Personal Representative

Legal Authority of Personal Representative

EFFECTIVE DATE OF NOTICE: