Adult Patient Questionnaire

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: lbs.
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

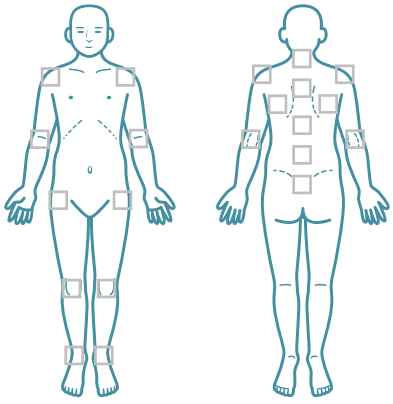
- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.



Have you received care for this problem before? Yes No

- If yes, please explain:

When did the condition(s) first begin?

How did the 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?

YOUR HEALTH GOALS

Your top three health goals:

1. _____

2. _____

3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ 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-based ◯ 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, list major injuries:

Any auto accidents? ◯ Yes ◯ No If yes, please explain:

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

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

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

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

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ Date: __/__/____

Dr. Kyle Heimer | Foundation Family Chiropractic
455 Old Trolley Rd. Ste A, Summerville, SC | 843-851-2417
FoundationFamilyChiropractic@gmail.com | www.FoundationFamilyChiropractic.com

Pregnancy Questionnaire

Patient Name: _____ Date: / /

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ○ Yes ○ No

- If not, please tell us about your previous pregnancy and/or birth experience(s).

Do you plan to follow the same plan as your previous delivery? ○ Yes ○ No

- If no, what would you like to change?

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date?

Did you have any difficulty conceiving? ○ Yes ○ No

- If yes, please explain:

Have you ever used any form of hormonal or oral contraceptives? ○ Yes ○ No

- If yes, which ones, and for how long?

When was your last menstrual cycle?

What was your pre-pregnancy weight? lbs. Current weight? lbs.

Have you experienced morning sickness? ○ Yes ○ No

- If yes, please explain:

CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently performing?

Please tell us about your current diet, and any dietary restrictions.

Have you taken any medications or supplements during your pregnancy? ○ Yes ○ No

- If yes, please explain:

Have you had any slips, falls, or other physical traumas during the pregnancy? ○ Yes ○ No

- If yes, please explain:

Have you had any major emotional stressors during your pregnancy? ○ Yes ○ No

- If yes, please explain:

YOUR BIRTH PLAN

Your top three goals for this pregnancy:

1. _____
2. _____
3. _____

Do you currently have a birth plan? ◯ Yes ◯ No

- If yes, please explain:

Are you taking any pre-natal or birthing classes? ◯ Yes ◯ No

- If yes, please explain:

Who is your OB/GYN or midwife? Will they be present for delivery? ◯ Yes ◯ No

Who is your birth provider?

Do you intend to have a doula or birth coach present? ◯ Yes ◯ No

- If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? ◯ Yes ◯ No

- If not, what concerns do you have?

YOUR POST-BIRTH PLAN

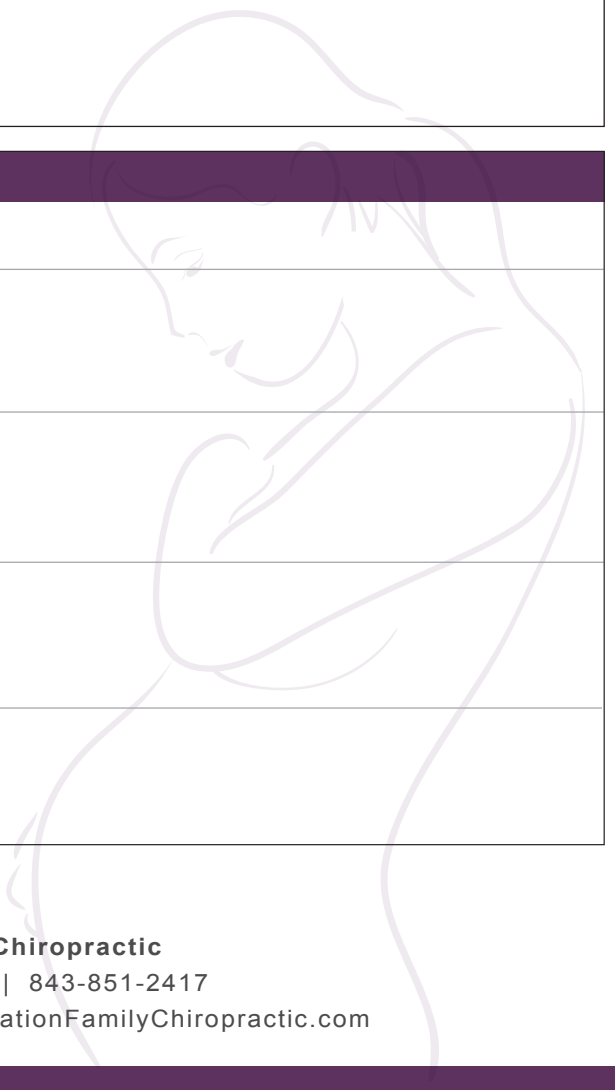
Do you plan on breastfeeding your child? ◯ Yes ◯ No

What do you intend to do for vaccines?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

What would you like to gain from chiropractic care during your pregnancy?

Are there any burning questions you want to be sure to ask today?



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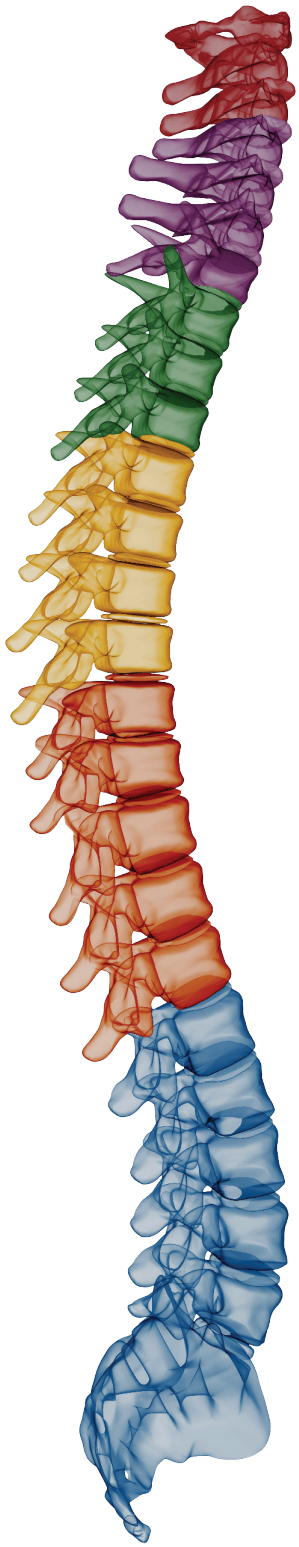
Patient Review of Systems

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.



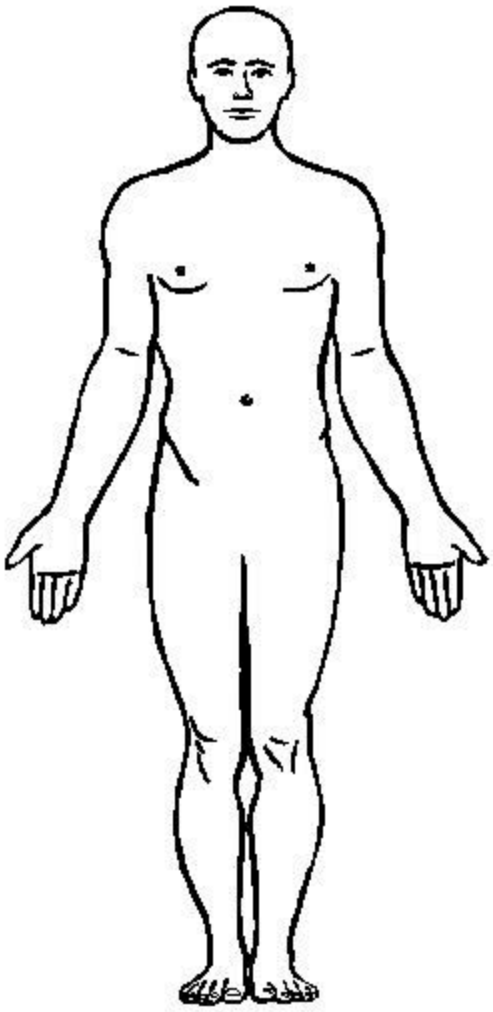
REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy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

Patient Name: _____ Date: __/__/__

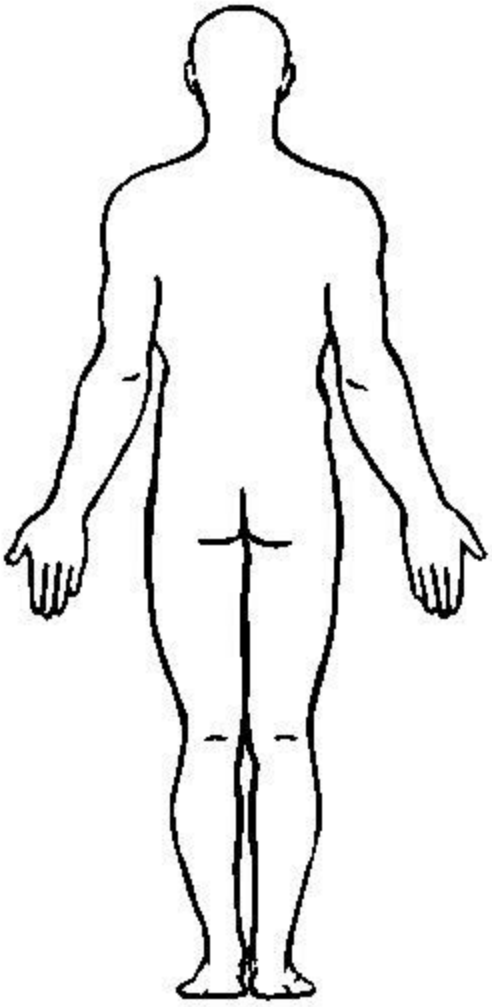
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked “O” for OTHER on any part, please explain below:

_____

_____

QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ **Date** _____

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:

	HEADACHE				NECK				LOW BACK			
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

---

1. What is your pain RIGHT NOW?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

2. What is your TYPICAL or AVERAGE pain?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

Foundation Family Chiropractic

455-A Old Trolley Road~Summerville~SC~29485
Dr. Kyle Heimer, D.C.

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby consent to the performance of chiropractic procedures, including spinal manipulations (adjustments), various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as a backup for the doctor of chiropractic named above.

I understand that chiropractic, like all forms of health care treatments, holds certain risks. While the risk is often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and strokes, which occur at a rate of 1 in 2 million people, have been associated with chiropractic adjustments. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels, based upon the facts then known, is in my best interest.

I confirm that I have an opportunity to discuss with the doctor or office staff the nature and purpose of chiropractic care and treatments. I have read, or have had read to me, the above consent and have had the opportunity to ask questions about its content. By signing below, I agree to chiropractic treatment as recommended by the doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Print Patient's Name	**Patient Signature**	**Date**

Below to be completed by patient's representative, if necessary (Patient is a minor or is incapable of completing form)

Print Representative's Name	**Representative's Signature**	**Relationship to patient**

NOTICE OF PRIVACY PRACTICE

I have read the Patient Privacy Notice, included with this paperwork and also located in the notebook in the waiting room. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this Notice of Privacy Practice at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and copies are kept in the waiting room and at the front desk. At this time, I do not have any questions about my rights or any of the information I have received.

Print Patient's Name	**Patient Signature**	**Date**

Below to be completed by patient's representative, if necessary (Patient is a minor or is incapable of completing form)

Print Representative's Name	**Representative's Signature**	**Relationship to patient**

Staff Will Fill Out Section Below if Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other: _____

_____	_____	_____
Staff Name	Staff Signature	Date

Insurance Information

Do You Currently Have Insurance? *(Please circle)* Yes No

Name of Insurance Company: _____

Insurance Policy Number: _____

Please Provide Us With Your Card So That We Can Make A Copy
You Will Also Be Asked For A Photo ID

Date of Birth: ____ ____ ____

Are You The Primary Policyholder On This Card? *(Please circle)* Yes No

If No, List The Name Of The Primary Card Holder: _____

Primary Cardholder's Date of Birth: ____ ____ ____

Do You Have Secondary or Supplemental Insurance? *(Please circle)* Yes No

Name of Insurance Company: _____

Insurance Policy Number: _____

Please Provide Us With Your Card So That We Can Make A Copy
You Will Also Be Asked For A Photo ID

Date of Birth: ____ ____ ____

Are You The Primary Policyholder On This Card? *(Please circle)* Yes No

If No, List The Name Of The Primary Card Holder: _____

Primary Cardholder's Date of Birth: ____ ____ ____

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ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the payment of all chiropractic benefits allowable and otherwise payable to me under my current insurance policy to Foundation Family Chiropractic, a payment for services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said service charges. If my current policy prohibits direct payment to my doctor, then I hereby also instruct and direct you to make the check out to me and mail it to the following address:

Dr. Kyle Heimer, D.C.
Foundation Family Chiropractic
455-A Old Trolley Road
Summerville, SC 29485

_____	_____	_____
Print Patient's Name	**Patient Signature**	**Date**

Below to be completed by patient's representative, if necessary (Patient is a minor or is incapable of completing form)

_____	_____	_____
Print Representative's Name	**Representative's Signature**	**Relationship to patient**