



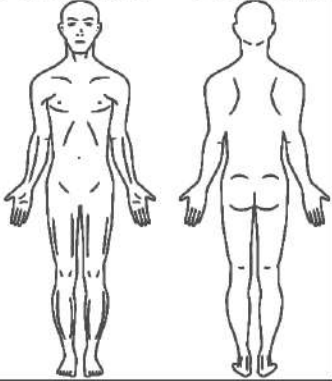
# ADULT PRACTICE MEMBER QUESTIONNAIRE

T 1 2 3 \_\_\_\_ / \_\_\_\_

## CONFIDENTIAL PRACTICE MEMBER INFORMATION

First Name:	Last Name:	Date:
SS#:	DOB:	Sex: <input type="radio"/> M <input type="radio"/> F
Spouse's Name (if married):	Names & Ages of Children:	Occupation:
Street Address:		Height:
City, State, Zip:		Weight:
Email:	Cell:	Appointment Reminders: <input type="radio"/> Text <input type="radio"/> Email
		Carrier:
Emergency Contact:	Emergency Relation:	Emergency Phone:
How did you hear about us?		
Date and reason for your last doctor visit:		
Are you also receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> 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?:	<div>Please indicate where you are experiencing pain or discomfort. X= Current condition    O= Past condition</div> 
Have you received care for this problem before? <input type="radio"/> Yes <input type="radio"/> No - If yes, please explain:	
When did the condition(s) first begin?	
How did the problem start? <input type="radio"/> Suddenly <input type="radio"/> Gradually <input type="radio"/> Post-Injury	
Is this condition: <input type="radio"/> Getting Worse <input type="radio"/> Improving <input type="radio"/> Intermittent <input type="radio"/> Constant <input type="radio"/> 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 ☐ 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 & 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 do 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						None				
	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						None				
	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





# PRACTICE MEMBER REVIEW OF SYSTEMS

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



## REGIONS

## FUNCTIONS

## SYMPTOMS

### Cervical

- Autonomic Nervous System
- ENT System
- Vision, Balance, & Coordination
- Speech
- Immune System
- Digestive System
- Nerve Supply to Shoulders, Arms & Hands
- Metabolism

PAST  
PRESENT

- ☐ Colic & Excessive Crying
- ☐ Ear & Sinus 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

PAST  
PRESENT

- ☐ 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 & Weight Control

### Upper Thoracic

- Upper G.I.
- Respiratory System
- Cardiac Function

- ☐ Reflux / GERD
- ☐ Chronic Colds & Cough
- ☐ Asthma

- ☐ Bronchitis & Pneumonia
- ☐ Functional Heart Conditions

### Mid Thoracic

- Major Digestive Center
- Detox & Immunity

- ☐ Gallbladder Pain / Issues
- ☐ Jaundice
- ☐ Fever

- ☐ Indigestion & Heartburn
- ☐ Stomach Pains & Ulcers
- ☐ Blood Sugar Problems

### Low 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
- ☐ Chrohn's, Collitis, & IBS
- ☐ Diarrhea
- ☐ Bed Wetting
- ☐ Bladder & Urination Issues
- ☐ Cramps & Menstrual Issues
- ☐ Cysts & Endometriosis
- ☐ Infertility
- ☐ Impotency
- ☐ Hemorrhoids

- ☐ Sciatica & Radiating Pain
- ☐ Lumbopelvic / SI Joint Pain
- ☐ Hamstring Tightness
- ☐ Disc Degeneration
- ☐ Leg Weakness & Cramps
- ☐ Knee, Ankle, & Foot Pain
- ☐ Weak Ankles & Arches
- ☐ Lower Back Pain
- ☐ Gluten & Casein Intolerance
- ☐ Poor Circulation & Cold Feet

Practice Member Name: \_\_\_\_\_ Date: \_\_\_\_\_



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## POLICIES AND FEE SCHEDULE

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- **Consultation** – includes patient history and current health concerns.
- **Assessment (*new or established patient*)** – Includes one or more of the following:  
thermography, surface electromyography, range of motion, motion and/or static palpation, leg check, postural assessment, vital signs.
- **Chiropractic Adjustment** – the actual re-alignment of the vertebrae done by hand or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place.

### RELEASE OF AUTHORIZATION / ASSIGNMENT OF BENEFITS

*I authorize and request payment of insurance benefits directly to Dr. Joseph Schmitt, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.*

### NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

*I understand that I have certain rights of privacy regarding my protected health information, under the health insurance portability and accountability act of 1996 (HIPAA). I understand that this information can and will be used to:*

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct a normal healthcare operations, such as quality assessments and physicians certifications.

*I acknowledge I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree with my requested restrictions, but if you agree you are bound to abide by such restrictions.*

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PRACTICE MEMBER'S SIGNATURE

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DATE





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## TERMS OF ACCEPTANCE

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In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you would acknowledge the following points regarding chiropractic care in the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of the spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with a specific intent of positioning misaligned spinal segments. This is a safe, effective procedure applied over 1 million times each day by Doctors of Chiropractic in the United States, alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indicators of need.
- E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care recommendations, home and self-care, etc., is essential to maximum healing in optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost. We work to maintain as a supporting, open environment.

***By my signature below, I have read and fully understand the above statements. All my questions regarding the doctors objectives pertaining to my care in this office have been answered to my satisfaction. I, therefore, accept chiropractic care on this basis.***

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PRACTICE MEMBER'S SIGNATURE

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DATE



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## INFORMED CONSENT FOR CHIROPRACTIC CARE

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Chiropractic care, like all forms of healthcare, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with care recommendations prior to beginning care.

***I understand and accept there are risks associated with chiropractic care. I give consent to the examination and the chiropractic care the doctor deems necessary, including spinal adjustments, as reported following my assessment.***

\_\_\_\_\_  
PRINT PRACTICE MEMBER'S NAME

\_\_\_\_\_  
PRACTICE MEMBER'S SIGNATURE

\_\_\_\_\_  
DATE

***If a practice member is a minor/child, parent or guardian must sign below.***

\_\_\_\_\_  
SIGNATURE OF PRACTICE MEMBER/GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP TO MINOR

\_\_\_\_\_  
WITNESS SIGNATURE (office staff)

\_\_\_\_\_  
DATE