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Adult Health Questionnaire

Huls Chiropractic

CONFIDENTIAL PATIENT INFORMATION

First Name: Last Name: Date:

Date of Birth: Age: Sex: ◯ M ◯ F Social Security #: Employer/School:

Marital Status: ◯ Single ◯ Married ◯ Widow/er ◯ Partnered # of children: Occupation:

Street Address Height: Weight:

City State Zip

Email: Cell Phone: Home/ Other:

Emergency Contact: Emergency Relation: Emergency Phone:

How did you hear about us? ◯ Friend/Family member: ◯ Workshop ◯ Facebook/Social Media ◯ Website/ Google

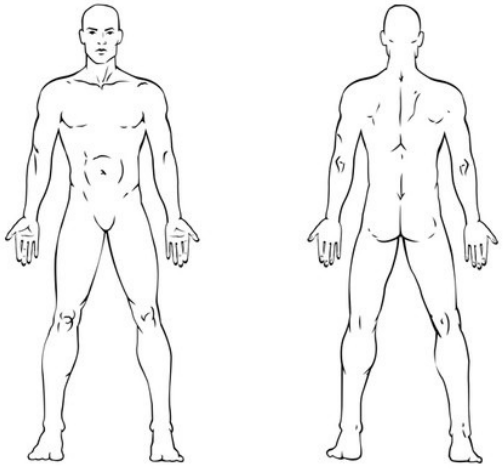
Who is your primary care physician? Date & Reason for your last visit:

Are you also receiving care from any other health professionals ◯ Yes ◯ No Physician Name:_____ Specialty:_____
If YES, please name them and their specialty

CURRENT HEALTH CHALLENGES

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

Please indicate where you are experiencing discomfort or any other health challenges



X = Current Issue D = Past Issue

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ◯ Sharp ◯ Dull ◯ Throbbing ◯ Numbness ◯ Aching ◯ Shooting ◯ Burning ◯ Tingling ◯ Cramps ◯ Stiffness ◯ Swelling ◯ Other_____

Have you received care for these challenges before? ◯ Yes ◯ No
If YES, please explain:

When did these challenges first begin?

How did these challenges start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Are these challenges getting: ◯ Better ◯ Worse ◯ Staying The Same ◯ Unsure

What makes these challenges BETTER?

What makes these challenges WORSE?

MY HEALTH GOALS:

My top 3 goals to help with current symptoms:

1.

2.

3.

CHIROPRACTIC HISTORY

What would you like to gain from Chiropractic care? ◯ Resolve existing challenges ◯ Overall wellness ◯ Both

Have you ever visited a Chiropractor? ◯ Yes ◯ No If YES, what is their name:_____

Was it a good experience? ◯ Yes ◯ No Approximately how long were you under care? #_____ Weeks Months Years

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based Other:_____

Specific reason for seeking care with us?

_____

_____

ACCIDENT INFORMATION

Is current condition due to an accident? ◯ Yes ◯ No Date_____ Type of accident ◯ Auto ◯ Work ◯ Home ◯ Other

To whom have you made a report of your accident? ◯ Auto Insurance ◯ Employer ◯ Worker's Comp. ◯ Other

Attorney Name (if applicable) _____

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:_____

Youth or college sports:_____

Any auto accidents?_____

Exercise frequency? ◯ None ◯ 1-2x/week ◯ 3-5x/week ◯ Daily

What type of exercise?:_____

How many hours do you sit on an average day? ◯ 2 hours or less ◯ 2-6 hours ◯ 6 hours +

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach I usually wake up: ◯ Refreshed & Alert ◯ Stiff & tired

Do you commute to work? ◯ Yes ◯ No If Yes, how many minutes each day?_____

List any problems with flexibility (ex: putting on shoes & socks, etc) _____

_____

List any problems with balance (ex: difficult to stand on one foot, dizziness, etc):_____

_____

List any other health challenges not already discussed:_____

_____

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		Moderate		High
Alcohol	1	2	3	4	5
Water	1	2	3	4	5
Sugar	1	2	3	4	5
Dairy	1	2	3	4	5
Gluten	1	2	3	4	5

	None		Moderate		High
Processed Foods	1	2	3	4	5
Artificial Sweeteners	1	2	3	4	5
Sugary Drinks	1	2	3	4	5
Cigarettes/ Tobacco	1	2	3	4	5
Exercise	1	2	3	4	5

Please rate your stress level for each:

	None		Moderate		High
Home	1	2	3	4	5
Work	1	2	3	4	5
Life	1	2	3	4	5

	None		Moderate		High
Health	1	2	3	4	5
Family	1	2	3	4	5

LADIES ONLY

Are you currently pregnant? ◯ Yes ◯ No If yes, what is the projected due date? _____

Have you had previous pregnancies? ◯ Yes ◯ No

What were the outcomes of all previous pregnancies? Vaginal Birth#_____ C-Section#_____ Miscarriage#_____ Other#_____

Have you experienced difficulty getting pregnant or carrying to full term in the past? ◯ Yes ◯ No

Do you have any other pregnancy related concerns? _____

HEALTH HISTORY

Date of Last: Physical Exam_____ Spinal Exam_____ Spinal X-Ray_____ Chest X-Ray_____
MRI, CT-Scan, Bone Scan_____ Blood Test_____

Please mark an X if you've HAD/HAVE any of the following:

AIDS/HIV____
Alcoholism____
Allergy Shots____
Anemia____
Anorexia____
Appendicitis____
Arthritis____
Asthma____
Bleeding Disorders____
Breast Lump____
Bronchitis____
Bulimia____
Cancer____
Cataracts____
Chemical Dependency____
Chicken Pox____
Diabetes____
Emphysema____
Epilepsy____
Fractures____
Glaucoma____
Goiter____
Gonorrhea____
Gout____
Heart Disease____
Hepatitis____
Hernia____
Herniated Disk____
Herpes____
High Blood Pressure____
High Cholesterol____
Kidney Disease____
Liver Disease____
Measles____
Migraine Headaches____
Mononucleosis____
Multiple Sclerosis____
Mumps____
Osteoporosis____
Pacemaker____
Parkinson's Disease____
Pinched Nerve____
Pneumonia____
Polio____
Prostate Problems____
Prosthesis____
Psychiatric Care____
Rheumatoid Arthritis____
Rheumatic Fever____
Scarlet Fever____
STD____
Stroke____
Suicide Attempt____
Thyroid Problems____
Tonsillitis____
Tuberculosis____
Tumors, Growths____
Typhoid Fever____
Ulcers____
Vaginal Infections____
Whooping Cough____
Other:_____
_____
_____

Medications: _____
_____
_____
_____

Allergies: _____
_____
_____
_____

Vitamins/Herbs/Minerals: _____
_____
_____
_____

If you've had any of the following, please describe and date if possible.

Falls:_____
_____

Head Injuries:_____
_____

Broken Bones:_____
_____

Dislocations:_____
_____

Surgeries:_____
_____

Patient HIPAA

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a written request. You may request to view changes to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my care and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date_____ Signature_____ Printed Name_____