Love and Health Chiropractic Questionnaire

Name_____ **Home Phone**_____

Address_____ **Cell Phone**_____

City_____ **State**_____ **Zip code**_____ **Date of Birth** __/__/__ **Gender**_____

Age_____ **SS#**_____ **Email**_____

Occupation_____ **Marital Status: M W D S Spouse Name**_____

No# of Children_____ **Name of Children**_____

Insured's Name (if other than self) _____ **Birth date** _____

1. **Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?**

   _____

2. **Science tells us that your spine, like your teeth, needs to be cared for regularly.**
   How often do you get adjusted by a chiropractor? Frequently/only when you hurt/1 x monthly/never

3. **When was your last complete spinal examination including x-rays?**_____ ☐ **Never**

4. **Do you know if you have a spinal curvature** ☐ **spinal arthritis** ☐ **or inherited spinal problem** ☐

5. **Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back as well as loss of Nerve Health. Do you hear these sounds when you move your head or neck?** ☐ **Yes** ☐ **No**

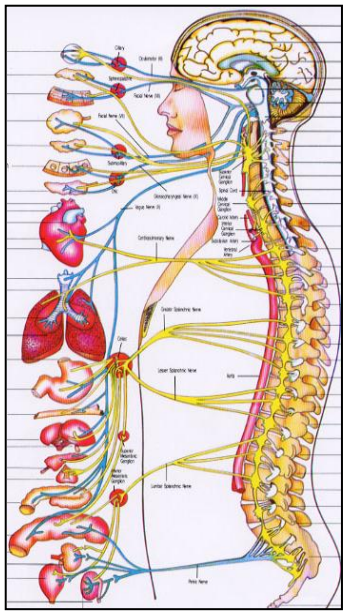
6. **If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back.**
   Do you often feel the need to crack or pop your neck or lower back? ☐ **Yes** ☐ **No**

7. **Poor posture leads to poor health and early death. How would you rate your posture?**
   Poor 1 2 3 4 5 6 7 8 9 10 Excellent

8. **Stress causes your spine to misalign and accelerates spinal damage. Rate your stress level over the last 3 months.**
   None 1 2 3 4 5 6 7 8 9 10 Intense

9. **Please circle or list any health symptoms or health complaints you are experiencing.**

Neck pain L/R	**Leg pain L/R**	**Heart Disease**	**Thyroid**
Mid-back pain	**Asthma**	**Cancer**	**Allergies:**_____
Low-back pain	**Headaches/Migraines**	**Constipation**	_____
Arm pain/Numbness L/R	**Diabetes I/II**	**Menstrual pain**	_____



10. **Prescription medications cause various side effects hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (use back if necessary)**
    1._____ **2.**_____ **3.**_____

11. **Please list any surgeries you have had.** _____

12. **Do You Smoke?** ☐ **Yes** ☐ **No**

13. **Spinal health is vitally important to ensure you and your baby are healthy. Is there a chance you are pregnant?** ☐ **Yes** ☐ **No**

14. **Daily trauma, auto accident(s), and work injuries can cause misalignment of vertebrae and serious spinal problems.**
    When was your most recent injury at home?_____ **Car accident?**_____ **Slip or fall?**_____

15. **Improper sleeping positions can cause spinal misalignment and spinal damage. What sleeping position do you sleep in:**
    ☐ **Back** ☐ **Stomach** ☐ **R Side** ☐ **L Side**

16. **Exercise level: Never 1 2 3 4 5 6 7 8 9 10 Often** 17. **Are you ?** ☐ **Right Handed** ☐ **Left Handed**

18. **Please list vitamins/supplements you take:**_____

19. **If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely?**
    ☐ **Yes** ☐ **No**

The above information is true and accurate to the best of my knowledge.

Patient Signature (Parent/Guardian):_____ **Date:**_____

Love and Health Chiropractic... Wellness Begins Here

1586 44th St SW, Wyoming, MI, 49509 **(616)455-7040** **dr.erik@lovehealthchiro.com**

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand or instrument. The doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare, it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name **Signature** **Date**

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature **Date**

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Notice of Privacy Practices

This notice describes how health information about you is stored, may be used, and or disclosed.

How We Store Your Information: Patient information is stored on a cloud based, secure server with no outside access. X-Rays images are also stored on the server and the hard copies of your file and X-Rays are stored here in our office. All storage is secure and meets or exceeds HIPAA requirements and regulations.

What We Do Not Do With Your Information: Information about your financial situation, medical conditions, and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about our patients to anyone who receives our services. Know that any and all patient information is considered confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your care, billing to an insurance company or to provide you with health or services which may require communication between Love and Health Chiropractic and health care providers, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications and insurance.

No Patients information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will ever be used without patient's express written advance permission.

Print Patient Name _____

Signature_____ Date _____

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This is to acknowledge my approval to allow Dr. Johnson or the staff at Love and Health Chiropractic to take my picture for the sole use of patient file identification only. **This photo will never be used for any purpose other than patient identification, nor will this photo or any information be shared with any outside source.**

Patient Signature: _____

Date: _____