# Adult Patient Questionnaire

Please PRINT clearly.

Today's Date:_____

PATIENT INFORMATION

Name: (Last, First, MI)_____ Preferred Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home:_____ Mobile:_____ Work:_____

Email:_____ Gender:_____ Marital Status: ☐Married ☐Single ☐Other

Best way to reach you: ☐ Home ☐ Cell ☐ Work ☐ Email Date of Birth:_____

Age:_____ Height:_____ Weight:_____ Occupation:_____ # of Children:_____

How did you hear about us? _____

Emergency Contact: _____ Relation to self: _____ Contact Number: _____

Who is your primary care physician? _____

Date and reason for your last doctor's visit:_____

Are you also receiving care from any other health professionals? ☐ Yes ☐ No

-If yes, provide name 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 this condition(s) first begin? _____

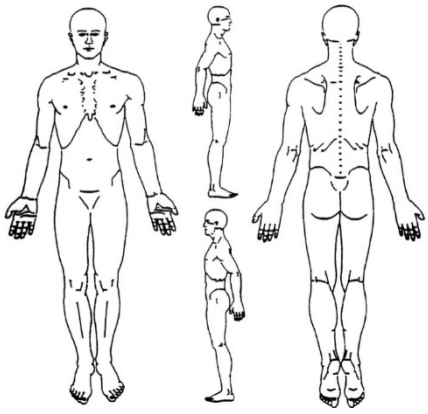
How did the problem start? ☐Suddenly ☐Gradually ☐Post-Injury

Is this condition: ☐Getting worse ☐Improving ☐Intermittent ☐Constant ☐Unsure

What makes the problem(s) better? _____

What makes the problem(s) worse? _____

Please indicate where you are experiencing pain or discomfort: X: Current Condition 0: Past Condition



YOUR HEALTH GOALS
What are 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, provide 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 of college sports? ☐Yes ☐ No If yes, list major injuries: _____

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

Exercise Frequency? ☐None ☐1-2x/week ☐3-5x/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.)* _____

TOXINS: Chemical & Environmental Exposure
How many hours per day do you spend sitting at a desk or on a computer, tablet, or phone? _____

| | 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 | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| Recreational Drugs | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

Please list any drugs, medications, vitamins, herbs, or any other things you are currently taking: _____

THOUGHTS: Emotional Stresses & Challenges

| | None | Moderate | | | High |
|---|---|---|---|---|---|
| Home | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| Work/School | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| Life | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

| | None | Moderate | | | High |
|---|---|---|---|---|---|
| Money | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| Health | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| Family | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

**Are you currently experiencing any of these symptoms? (Check all that apply)**
**Many of the following conditions respond to Chiropractic and Acupuncture treatment.**

**General:** (constitutional)
☐Recent Weight Gain
☐Fever
☐Fatigue
☐*None in this category*

**Musculoskeletal:**
☐Low Back Pain
☐Mid Back Pain
☐Neck Pain
☐Arm Problems _____
☐Leg Problems _____
☐Painful Joints
☐Stiff/Swollen joints
☐Sore/Weak Muscles or Joints
☐Muscle Spasms/Cramps
☐Broken Bones
☐Other: _____
☐*None in this Category*

**Neurological:**
☐Numbness or Tingling Sensations
☐Loss of Feeling
☐Dizziness or Light Headed
☐Frequent or Recurrent Headache
☐Convulsions or Seizures
☐Tremors
☐Strokes
☐Have you ever had a head injury?
☐Ever been in an auto accident?
☐Other: _____
☐*None in this Category*

**Mind/Stress:**
☐Nervousness
☐Depression
☐Sleep Problems
☐Memory Loss or Confusion
☐Other:_____
☐*None in this category*

**Genitourinary:**
☐Sexual Difficulty
☐Kidney Stones
☐Burning/Painful Urination
☐Change in Force/Strain w/Urination
☐Frequent Urination
☐Blood in Urination
☐Blood in Urine
☐Incontinence or Bed Wetting
☐Other:_____
☐*None in this category*

**Gastrointestinal:**
☐Loss of Appetite
☐Blood in Stool
☐Change in Bowel Movements
☐Painful Bowel Movements
☐Nausea or Vomiting
☐Abdominal Pain
☐Frequent Diarrhea
☐Constipation
☐Other:_____
☐*None in this category*

**Cardiovascular & Heart:**
☐Chest Pains
☐Rapid or Heartbeat Changes
☐Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
☐Heart Problems
☐Other:_____
☐*None in this category*

**Respiratory:**
☐Difficulty Breathing
☐Persistent Cough
☐Coughing Blood
☐Asthma or Wheezing
Lung Problems
☐Other:_____
☐*None in this Category*

**Eyes and Vision:**
☐Wear contacts/glasses
Blurred or Double Vision
☐Glaucoma
Eye Disease or Injury
☐Other:_____
☐*None in this Category*

**Ears, Nose and Throat:**
☐Bleeding gums/Mouth sores
☐Bad Breath or Bad Taste
☐Dental Problems
☐Swollen Throat or Voice Change
☐Swollen Glands in Neck
☐Ringing in the Ears
☐Ear-Ache/Ringing/Drainage
☐Sinus/Allergy Problems
☐Nose Bleeds
☐Hearing Loss
☐Other:_____
☐*None in the Category*

**Endocrine, Hematologic, and Lymphatic:**
☐Thyroid problems
☐Diabetes
☐Excessive Thirst or Urination
☐Cold Extremities
☐Heat or cold intolerance
☐Change in hat or glove size
☐Dry Skin
☐Glandular or Hormone Problem
☐Swollen Glands
☐Anemia
☐Easily Bruise or Bleed
☐Phlebitis
☐Transfusion
☐Immune System Disorder
☐Other:_____
☐*None in this Category*

**Skin and Breasts:**
☐Rash or Itching
☐Change in Skin Color
☐Change in Hair or Nails
☐Non-healing Sores
☐Change of Appearance of a Mole
☐Breast Pain
☐Breast Lump
☐Breast Discharge
☐Other:_____
☐*None in this Category*

**Women Only:**
**Are you pregnant?**
☐Yes-Due Date_____
☐No-Last Menstrual Period_____
☐Infertility
☐Painful or Irregular Periods
☐Vaginal Discharge
☐Other:_____
☐*None in this Category*

**Pregnancies with Outcome & Date**
_____
_____
_____
_____

**Is there anything else you would like the doctor to know?**_____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature of frequency of chiropractic care).

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

**Sozo Chiropractic LLC**

**Dr. Alyssa O'Connor**

**22386 Harrison St. Spring Hill, KS 66083**

**Notices of Privacy Practices**

**HIPPAA**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and updated laws, 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 treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. *Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I many contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I many request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I further authorize disclosure of all or any part of my patients record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to ta family member or employer of the patient for all or part of the clinics charge including, not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

**Consent Regarding: Chiropractic adjustments, modalities, and therapeutic procedures**
I have been advised that chiropractic care, like all forms of health care, hold certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible strong-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Sozo Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby, consent to treatment by any means, methods, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____
Patient Name (print) witness initials

_____ _____/_____/_____
Patient Signature Date

**Clinical Summary Report (CCR) regarding HER**
I understand that a clinical summary report is created after each visit for the purpose of HER and is available for my review. At this time, I am asking Sozo Chiropractic LLC to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

**Assignment of Benefits**
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

**Media Release**
I understand and give permission to Sozo Chiropractic LLC, to share my chiropractic story. I give my permission for the following information to be shared: (first name, age, picture, video, treatment results) by the following ways: (in office, social media, website).

**Print Patient Name:** _____

**Authorized Signature:** _____

**Relationship to patient (if not self):** _____

**Date:** _____

**DO NOT SIGN** past this point as we will go over this information with you during the exam.

**Report of Finances**
(Fee for services)

The following are services that our office will not be billing to insurance companies. The items/services listed below may or may not be covered when preformed in this office by our providers. Patient understands they are seeking treatment for correction of vertebral subluxation.

Initial Consultation Fee: $125
Fee includes the following:
*Examination
*Neurological scans
*Report of findings

**Patient or Guardian Signature: _____ Date:_____**