

### CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete this form as accurately as possible. Your answers will help us determine whether chiropractic can help you. If we do not sincerely believe your condition can respond satisfactorily, we will not accept the case. Thank you for your cooperation.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ Alternate #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**(Please Circle)** Male or Female **Marital Status:** M S W D **Spouse's Name:** \_\_\_\_\_

Do you have any children?  Yes  No If yes, how many? \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

What name would you like to be called in our office? \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who is responsible for payment of the bill? \_\_\_\_\_

Physical activity at work:  No Manual Labor  Light Manual Labor  Moderate Manual Labor  Heavy Manual Labor

How would you grade your general stress level?  No Stress  Minimal Stress  Moderate Stress  Greatly Stressed

#### Current Problems

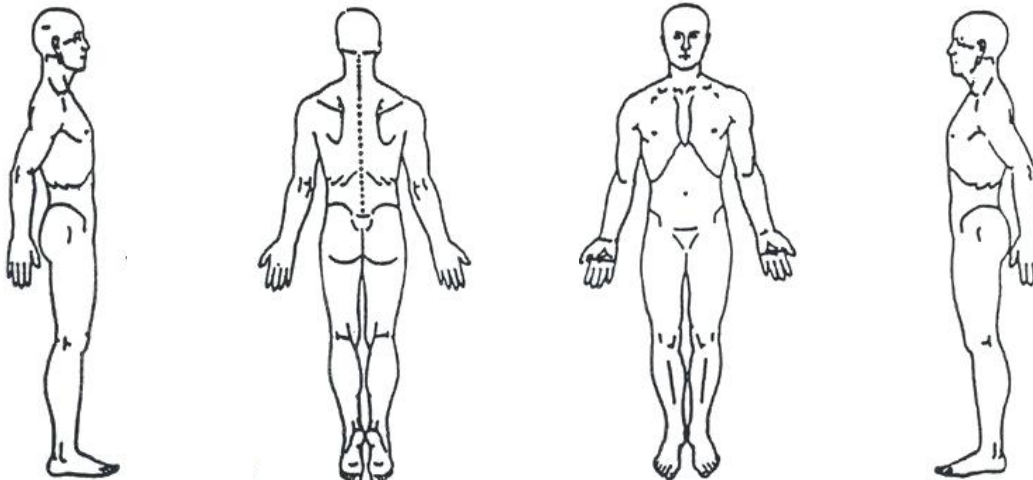
What kinds of problems are you having today? \_\_\_\_\_

When did this problem begin? (Specific date if possible): \_\_\_\_\_

Do you know how your problem began? \_\_\_\_\_

Please describe your current pain (Check all that apply):  Sharp/Stabbing  Sharp/Dull  Aches  Dull  Soreness  Weakness  Throbbing/Gnawing  Numbness  Shooting  Gripping/Constricting  Burning  Tingling

**PLEASE MARK AN "X" ON THE BODY BELOW WHERE YOU HAVE PAIN OR DISCOMFORT, INCLUDING NUMBNESS OR TINGLING**



Are your complaints affecting your ability to work or otherwise be active?  Yes  No

If yes, please check the one you are closest to:

- Need limited assistance with everyday tasks       Have a significant inability to function without assistance  
 Some physical restrictions (need assistance often)       Totally disabled (impaired). Cannot care for self.

Have you consulted other doctors for these symptoms?  Yes  No

If yes, please list the name, date(s) seen, and type of treatment: \_\_\_\_\_

Is this the first time you've had these symptoms?  Yes  No

If no, were you previously treated for these symptoms?  Yes  No

If yes, please specify dates and type of treatment: \_\_\_\_\_

### Past Medical History

Name and Address of Medical Doctor: \_\_\_\_\_

Doctor Phone #: (\_\_\_\_) \_\_\_\_\_

Date of last: Physical Exam: \_\_\_\_\_ Blood Pressure Check \_\_\_\_\_ X-Rays \_\_\_\_\_

List any current medications: \_\_\_\_\_

Are there any illnesses in your family?  Yes  No If yes, please specify: \_\_\_\_\_

Any prior auto, work, or other accidents?  Yes  No If yes, please give dates and details: \_\_\_\_\_

General physical activity:  No Regular Exercise     Light Regular Exercise     Strenuous Exercise

**Please check the appropriate box if any of the following apply to you (past or present)**

<u>GENERAL</u>	Severe	Mod	Mild	<u>GASTROINTESTINAL</u>	Severe	Mod	Mild	<u>DO YOU HAVE</u>	Yes	No
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Colds/Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>RESPIRATORY</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
				<u>MUSCLE &amp; JOINT</u>				<u>FOR WOMEN ONLY</u>		
<u>GENITO-URINARY</u>				Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arm/Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycle	<input type="checkbox"/>	<input type="checkbox"/>
Inability to Control Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in Breast	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infection or Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble/Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Prostate Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>HABITS</u>		
				Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea _____Cups/Day		
<u>CARDIO-VASCULAR</u>				Pain between Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco _____Pack(s)/_____		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol _____Drink(s)/_____		
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rib Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep _____Hrs./Night		
Swelling of Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

## HIPAA Privacy Notice

At Optimal Chiropractic, we have always kept your health information secure and confidential. We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a description your rights as a patient under the law. **You have the right to review our Notice before signing this Consent and you are advised to do so.**

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

### The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices. The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients. Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We WILL NOT ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions. The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

### Acknowledgement:

I have received a copy of the Optimal Chiropractic (Dr. Kassandra Walkowiak) Practice and Privacy Notices.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

### INFORMED CONSENT

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks:** I have had the following unusual risks of my case explained to me.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**WITNESS:**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date