Adult Chiropractic Health Questionnaire

Name _____ Home Phone _____

Address _____ Work Phone _____

City, State, Zip _____ Cell Phone _____

Age _____ SS# _____ Male___ Female ____ Marital Status: M S

E-mail Address _____Birth date _____

Occupation _____ Employer _____

Spouse Name _____ Spouse's Birth date: _____

Emergency Contact Name _____ Emergency Contact Number _____

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name _____
☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ ☐ Never

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

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ YES ☐ NO _____

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? ☐ YES ☐ NO

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? ☐ YES ☐ NO

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

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

1. _____ 2. _____ 3. _____

10. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

_____

11. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ☐ YES ☐ NO Date of Incident _____

12. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? ☐ YES ☐ NO

13. Have you ever been diagnosed with cancer? ☐ YES ☐ NO

Type _____ Year _____

14. If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations? ☐ YES ☐ NO

INSURANCE AUTHORIZATION

Do you have health insurance? _____ Name of Company_____

Subscriber's Name _____ Date of Birth _____

Subscriber's relationship to Patient: _____ Subscriber's SS# _____

Subscriber address: _____ City_____ State____ Zip_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Authorization Signature_____ Date_____

ONLY For patients under the age of 18 years old:

Consent to Treatment of Minor Child

I hereby authorize McCormick Chiropractic of Pottstown, PA and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my _____(indicate relationship of child), _____(name of child).

Parent/Guardian Signature_____ **Date**_____

Parent/Guardian Name:_____ Phone: _____ Cell:_____

Name of Parent/Guardian *responsible* for Patient's Account: _____

Address (if different from address of patient): _____

Phone: _____ Cell:_____

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

Patient Signature _____ Date _____