Adult/Teen Health Questionnaire

Welcome to Adjusting the World Chiropractic

Name: _____Date:_____

*Please make sure you have completed the **Patient Online Intake form from our website**. The following pages are designed to give us further information about your health and lifestyle, which will allow us to better serve you. It also includes forms requiring signatures, including privacy (HIPAA), our financial policy, and informed consent for treatment. Thank you and we look forward to serving you!*

Wellness Profile

Throughout the exam, the doctor will be searching for one thing: the CAUSE of your health challenge. Chiropractic wellness care seeks to find the causes of a health challenge, rather than simply trying to artificially alleviate the symptoms. The following questions are vital to finding the cause of your current health condition and finding solutions to your health challenge. It is important to investigate the types of stresses to know where your body is accumulating stress, which decreases your body's ability to perform at an optimal level. Please take your time answering these questions, including anything that you may feel is related to your current complaints.

Physical

Describe your birth process: Long Delivery Cesarean Forceps Vacuum Breech Induction Epidural

Circle any experiences as a child/teen:

Fall out of Bed
Childhood sicknesses: (please list)
_____
Growing Pains
Child Abuse
Fall down the Stairs
Yanked by the Arm
Fall off your bike/out of tree, etc.

Rate the following on a scale 1-10 (10 being Excellent):

Exercise: _____ When and what? _____
Posture: _____
Sleep: _____ Hours per day? _____Position_____

Do you stretch regularly?	**Yes**	**No**
Do you do cardio regularly?	**Yes**	**No**
Do you do strength training regularly?	**Yes**	**No**
Do you change your workout routine?	**Yes**	**No**
Belong to health club?	**Yes**	**No**

How do you spend the majority of your day? **Seated Standing Other:** _____
Do/did you play sports? **Yes No** **What do/did you play?** _____

Biochemical

Were you vaccinated as a child?	**Yes**	**No**
Were you on medications as a child?	**Yes**	**No**
Drink Bottled water?	**Yes**	**No**
Drink Soda? (Diet or Regular)	**Yes**	**No**
Do you have an air purifier?	**Yes**	**No**

Are you exposed to any of the following (circle):

artificial sweeteners	refined sugar
antiperspirant	medications
cleaning chemicals	nutritional deficiencies
microwaved foods	processed foods
fast foods	fatty foods

How many servings do you have per day: **Fruits? ____ Vegetables? _____ Meat? _____ Dairy? _____**
How frequently do you eat per day? **1-2 meals 3-4 meals 5-6 meals snack all day**

Emotional

What do you do for stress relief? _____
What causes you the most stress? _____

Rate the following on a scale of 1-10 (10 being Best):

Your stress level: Personal: _____
Occupational: _____
Daily Positive Thoughts: _____
Taking time for you: _____
Doing things you love: _____

Have you experienced: (Approx. Date)

Loss of a loved one: _____
Experienced Divorce: _____
Had a serious illness/pain: _____
Been Depressed: _____
Suffered from Anxiety: _____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service.

Signature _____ Date: _____

Financial Policy

IN–NETWORK GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify your benefits. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered, you are personally responsible for payment of any applicable deductibles, co-insurance or co-pays.

MEDICARE

We accept assignment from Medicare and we will submit your claims for you. The check is usually sent directly to our office. The ONLY services that Medicare will cover when provided by a Chiropractor is manual manipulation of the spine. Maintenance and preventative service is not covered. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NONCOVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Maintenance and preventative service is not covered. Secondary insurance may or may not pay for these non-covered services. Please see IN-NETWORK GROUP OR INDIVIDUAL INSURANCE for payment policy.

SECONDARY INSURANCE

Please inform us of any secondary insurance.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

If you have a flex spending account we will be happy to provide you with a statement of your charges for reimbursement. (First statement of each year is no charge. Each subsequent statement will have a $5 charge)

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS &"ON THE JOB" INJURY (Worker's Compensation)

Separate financial policies are enforced for PI and WC cases. Refer to Adjusting the World Paperwork for details.

CASH PAYING PATIENTS

If you do not fall under any of the other categories of payment, you are a **CASH** patient. Since there is no insurance to bill and there are no others responsible for your account, you are expected to pay for your visit at the time of service. You may pay with CASH, CHECK, or CREDIT CARD. We do not carry patient balances unless you have been approved for a payment plan through Care Credit, or have signed up for a monthly payment plan. For Care Credit applications and additional information on how to use Care Credit's no interest payment plans, please ask …We're happy to help!

I have read and understand the payment policy of Adjusting the World Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Adjusting the World Chiropractic and my insurance company. I request that Adjusting the World Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits.

_____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness

Informed Consent for Chiropractic Care

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

_____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____being of the parent or legal guardian of_____

_____

Signature Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

_____

Print Name Signature Date

If patient is a minor or under a guardianship order as defined by State law:

I, _____being of the parent or legal guardian of_____

_____

Signature Date