

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name: _____ Last Name: _____ Date: _____

SS#: _____ DOB: _____ Sex: M F

Marital Status: _____ # of Children: _____ Occupation: _____

Street Address: _____ Height: _____ ft. _____ in.

City: _____ State: _____ Zip: _____ Weight: _____ lbs.

Email: _____ Cell Phone: _____ Other Phone: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

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

- If yes, please name them 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 the condition(s) first begin?

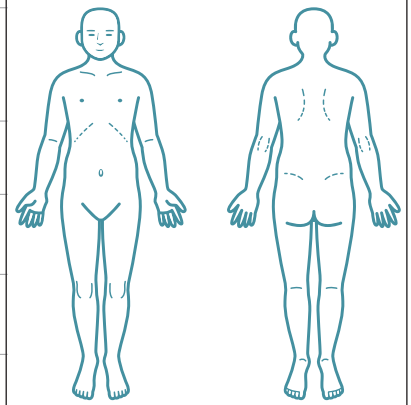
How did the problem start? Suddenly Gradually Post-Injury

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.



YOUR HEALTH GOALS

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, what is their 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 or college sports? Yes No If yes, list major injuries:

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

Exercise Frequency? None 1-2x per week 3-5x per 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.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	<i>None</i>						<i>Moderate</i>						<i>High</i>				
	①	②	③	④	⑤		①	②	③	④	⑤		①	②	③	④	⑤
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤		①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤		①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤		①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤		①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤		①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	<i>None</i>						<i>Moderate</i>						<i>High</i>				
	①	②	③	④	⑤		①	②	③	④	⑤		①	②	③	④	⑤
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤		①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤		①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤		①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

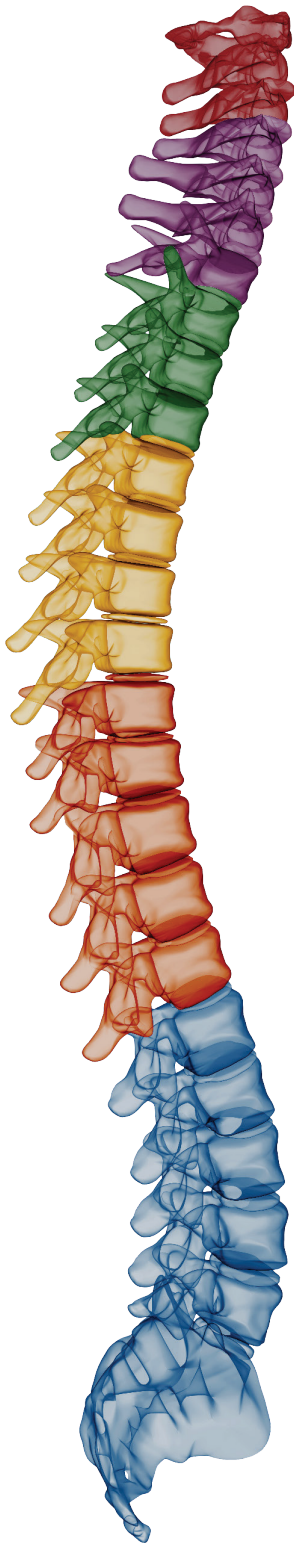
Patient Name: _____ Date: _____

Dr. Debbie Pun | Platinum Chiropractic
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385-204-4125

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS						
		PAST	PRESENT	PAST	PRESENT			
Cervical	• Autonomic Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy & Seizures	
	• ENT System	<input type="checkbox"/>	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sensory & Spectrum	
	• Vision, Balance & Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD	
	• Speech	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Focus & Memory Issues	
	• Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety & Stress	
	• Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Balance & Coordination	
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues	
	• Sympathetic Nucleus	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	TMJ / Jaw Pain	
	• Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck & Shoulders	
			<input type="checkbox"/>	<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Depression
			<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
			<input type="checkbox"/>	<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	<input type="checkbox"/>	Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis & Pneumonia	
	• Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	<input type="checkbox"/>	Functional Heart Conditions	
	• Cardiac Function	<input type="checkbox"/>	<input type="checkbox"/>	Asthma				
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion & Heartburn	
	• Detox & Immunity	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pains & Ulcers	
		<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar Problems	
Lower Thoracic	• Stress Response	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Eczema	
	• Filtration & Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions / Rash	
	• Gut & Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	
	• Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica & Radiating Pain	
		<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/>	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain	
	• Gut-Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hamstring Tightness	
	• Major Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Disc Degeneration	
		<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness & Cramps	
		<input type="checkbox"/>	<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation & Cold Feet	
		<input type="checkbox"/>	<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Knee, Ankle & Foot Pain	
		<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Weak Ankles & Arches	
		<input type="checkbox"/>	<input type="checkbox"/>	Impotency	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	
		<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Gluten & Casein Intolerance	

Patient Name: _____ Date: _____

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

Signature:

Date:

Guardian or spouse authorizing care signature:

Date:

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict my personal information is used and or disclosed.

Patient Name (Please Print):

Relationship to Patient:

Signature:

Date:

Photos and Video Permission

Platinum Chiropractic takes pictures and videos for clinical and training purposes. I give Platinum Chiropractic permission to take additional photos and videos of me that may be used in office promotion, fliers, social networks, such as Facebook, Instagram or Youtube and/or the website www.platinumchirout.com

Signature:

Date:

Guardian or spouse authorizing care signature:

Date:

What Platinum Chiropractic is all about...

Our Vision: It is our vision that every man, woman, and child be checked regularly for subluxation throughout their lives.

Our Mission: It is our mission to educate and grow a healthy community and assist one in achieving optimal health through specific chiropractic care.

Our Purpose: To provide the best opportunity for members of our community to live long, healthy, happy lives from their first breath to the last so they can fully engage in life and provide value to their families and community.

Our Premise: Families that are in our office are more equipped to handle the stress of everyday life.

Our Core Values:

Passion: We have a passion for service, life, and chiropractic.

Professionalism: We exhibit the skill, judgment, and behavior that is expected from a person who is trained to do a job well.

Teamwork: Our team works together by combining each of our unique strengths to create an environment that allows us to provide outstanding value to our community in a very simple and efficient way.

Love: Our service to our community is rooted by an unselfish and compassionate concern for the good of each individual we care for.

Authenticity: Each member of our team behaves in a manner that allows him or her to stay true to one's own personality, spirit, and character.

Integrity: We adhere to a code of having high moral values when serving and communicating the chiropractic paradigm to the world.

Simplicity: We act efficiently and communicate in a way that is easy to understand. We are experts at simplifying the complex.