Thiede Chiropractic's Health Questionnaire **CASE NO. _____**

Please fill out the following form in as much detail as possible. Date_____

Name_____

Address_____

City _____ State _____Zip _____

Home Phone _____ Office Phone _____Cell Phone _____

E-mail Address _____Soc. Sec. Number_____

Age _____ Date of Birth _____ Occupation _____ Sex (M) ___ (F) ___

Weight _____ Height_____ Referred by _____

Employer _____ Address _____

Married _____ S _____W _____D _____ Children _____ Name of Spouse _____

Is any other member of your family being treated in this office?_____

Have you ever had chiropractic care before? _____

For what problem? _____

Who can we thank or how did you hear about us? _____

CURRENT PROBLEM:

Major complaints and symptoms – please be as specific as you can. Ask the doctor or assistant to help if you need assistance in filling out this section. _____

_____

_____

How do you believe your problem (pain) began? _____

_____

_____

_____

When did you first notice this problem / pain? _____

Have you lost any work? _____ Day and date you last worked_____

Have you ever had this condition before or a similar condition? _____

When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you been treated by a Medical Physician for this condition? _____

Where? _____

Describe the type of treatment _____

Diagnosis of previous physician _____

Length of time under care_____ Results _____

Family physician's name _____

Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? Yes___ No___

Do you take vitamins? Yes___ No___ If yes, please list them _____

_____

Do you exercise regularly? Yes___ No___ What kind of exercise? _____

_____

Habits: (please check)

Cigarettes _____ Quantity _____ Coffee _____ Quantity _____

Alcohol _____ Quantity _____ Tea _____ Quantity _____

Hobbies _____

Have you been treated for any health condition by a physician in the past year? _____

If Yes, what condition? _____

Are you seeing any other doctor now for any reason? Yes___ No___

Will this case be covered by any insurance company? Major Medical ___ Auto ___ Blue Cross/Blue Shield___ Workers' Compensation ___ Medicare ___ Other ___

PAST MEDICAL HISTORY:

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)? _____ When? _____

Are you presently taking any medication (i.e. birth control, aspirin included)? Yes ___No___

If yes, name them _____

Have you ever broken any bones? (fractures)_____ Any dislocations? _____

What operations have you had? _____ Year _____

_____ Year _____

_____ Year _____

Have you had any cosmetic surgery, breast implants, etc.? _____ Year _____

Have you had any surgery to replace hip, knee, etc? _____ Year _____

Give dates you have had any of the following (if exact date is unknown, give approximate date)

Blood tests _____ Urinalysis _____

MRI_____ CT Scan _____ Ultrasound _____

Radiation treatment_____ X-Ray examination _____

Other special treatment _____

At what hospital or office were these tests taken? _____

Name of doctor who ordered tests _____

Have you had or do you now have any of the following symptoms which are or have been significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now **N**	**Past** **P**		**Now** **N**	**Past** **P**
Headaches	____	____	Frequent Loss of Balance	____	____
Neck Pain	____	____	Fainting	____	____
Stiff Neck	____	____	Loss of Smell	____	____
Sleeping	____	____	Problems/Loss of Taste	____	____
Back Pain	____	____	Diarrhea	____	____
Nervousness	____	____	Feet Cold	____	____
Tension	____	____	Hands Cold	____	____
Irritability	____	____	Arthritis	____	____
Chest Pains	____	____	Muscle Spasms	____	____
Dizziness	____	____	Frequent Colds	____	____
Shoulder/Neck/Arm Pain	____	____	Stomach Upset	____	____
Pins & Needles in Arms	____	____	Constipation	____	____
Pins & Needles in Legs	____	____	Cold Sweats	____	____
Numbness in Fingers	____	____	Fever	____	____
Numbness in Toes	____	____	Sinus Problems	____	____
High Blood Pressure	____	____	Diabetes	____	____
Difficulty Urinating	____	____	Hemorrhoids	____	____
Allergies	____	____	Leg Cramps	____	____
Weakness in Arms	____	____	Colitis	____	____
Weakness in legs	____	____	Gall Bladder	____	____
Shortness of Breath	____	____	Indigestion	____	____
Fatigue	____	____	Belching	____	____
Depression	____	____	Vomiting	____	____
Lights Bother Eyes	____	____	Shoulder Pain	____	____
Loss of Memory	____	____	Swelling Joints	____	____
Ears Ring	____	____	Knee Pain	____	____
Face Flushed	____	____	Hay fever	____	____
Buzzing in Ears	____	____	Menstrual Difficulties	____	____

Do you have any health problems not listed above? _____

FAMILY HISTORY

Did your mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both

( )High Blood Pressure
( )Heart Attack
( )Emphysema
( )Seizures-Convulsions
( )HIV Positive
( )Asthma
( )Diabetes
( )Kidney Disease
( )Pacemaker
( )Ulcer or Stomach Problems
( )Stroke
( )Arthritis-Rheumatism
( )Mental Illness
( )Thyroid Disease
( )Circulation Problems
( )Cancer
( )Osteoporosis

THIEDE CHIROPRACTIC'S TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those finding, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(Patient Signature or Guardian) (Date)

Consent to Evaluation and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Thiede, D.C. and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. Thiede, D.C. I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Our Privacy Policy

The office of Dr. Thiede, D.C. is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Dr. Thiede, DC may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

Financial Policy

Thiede Chiropractic works diligently to get proper payment by your insurance company for services rendered in our clinic. We call your insurance to get a verification of your benefits. What they quote us is an estimate of payment, not a guarantee of payment. When we receive the payment from your insurance company, we will inform you of the balance not covered by your insurance on your next visit. The **FULL AMOUNT** is due on your next visit. Our office accepts Visa, Mastercard, and Discover Card. **We do not carry accounts within our office.** We greatly appreciate your business and strive to earn your trust for a lifetime. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charged 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 me will be immediately due and payable.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy and financial policies, and that I certify that my medical information above is correct to the best of my knowledge.

Patient or Guardian's Signature_____ **Date** _____

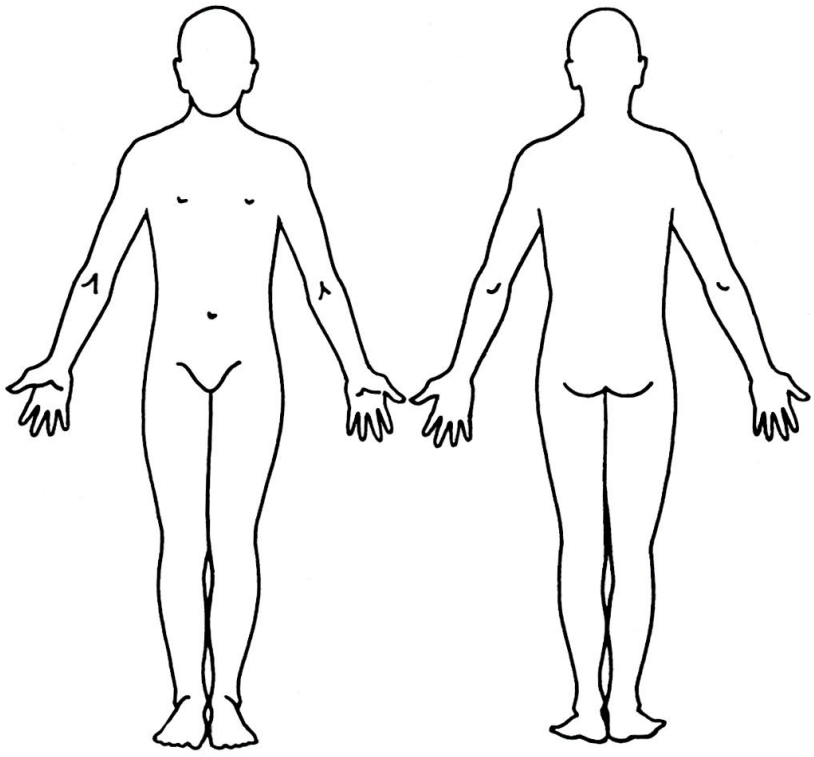
Chiropractor's Signature: _____ **D.C.**

PAIN DIAGRAM

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING
Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Right Left Left Right

Neck/Shoulder Arm Pain
On a scale of zero to 10, I rate my discomfort as follows
(_____)
0 **10**
no pain **severe pain**

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows
(_____)
0 **10**
no pain **severe pain**

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows
(_____)
0 **10**
no pain **severe pain**

Date: _____ Signature _____