Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SS #:	DOB:	Sex: ○ M ○ F
Marital Status:	# of Children:	Occupation:
Street Address:		Height:
City, State, Zip:		Weight:
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emergency Relation:	Emergency Phone:

How did you hear about us?

Who is your primary care physician?

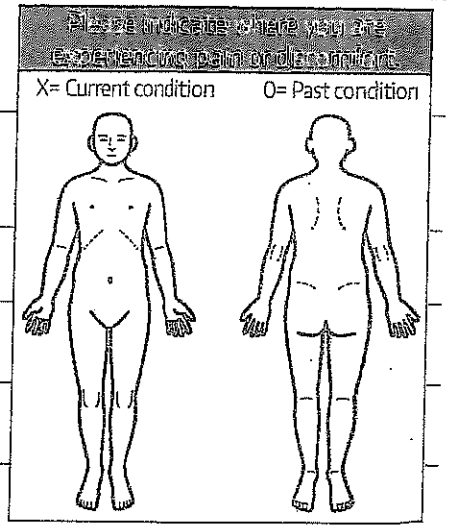
Date and reason for your last doctor visit:

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

s this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

What makes the problem worse?

OUR HEALTH GOALS

our top three health goals:

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 ○ 3-6x 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:

	None		*Moderate*		*High*
Alcohol	①	②	③	④	⑤
Water	①	②	③	④	⑤
Sugar & Sweets	①	②	③	④	⑤
Dairy	①	②	③	④	⑤
Gluten	①	②	③	④	⑤

	None		*Moderate*		*High*
Processed Foods	①	②	③	④	⑤
Artificial Sweeteners	①	②	③	④	⑤
Sugary Drinks	①	②	③	④	⑤
Cigarettes	①	②	③	④	⑤
Recreational Drugs	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:

	None		*Moderate*		*High*
Home	①	②	③	④	⑤
Work	①	②	③	④	⑤
Life	①	②	③	④	⑤

	None		*Moderate*		*High*
Money	①	②	③	④	⑤
Health	①	②	③	④	⑤
Family	①	②	③	④	⑤

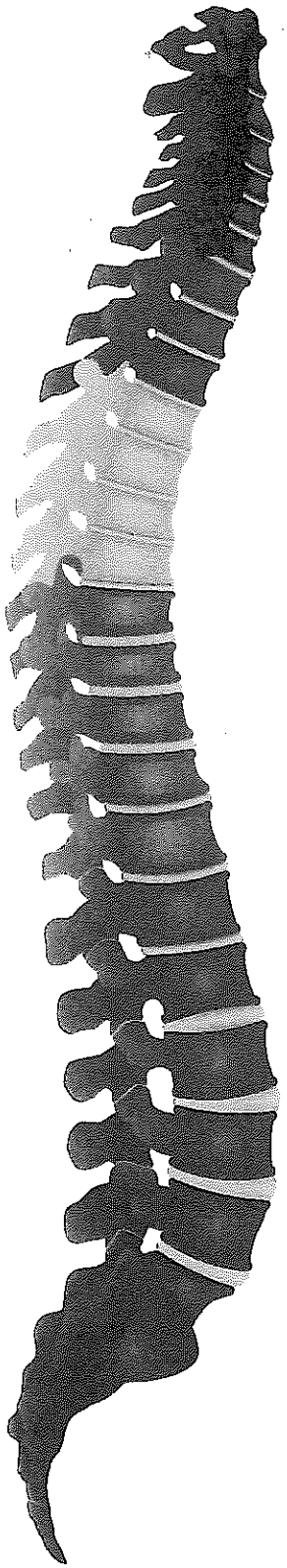
ACKNOWLEDGMENT & CONSENT

Patient Name: _____ Date: _____

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

Patient Name _____ Date _____

Bakersfield Chiropractic, Perry Chiropractic, Inc.
Dr. Stephanie M. Perry & Dr. William E. Perry
3900 Truxtun Avenue * Bakersfield, CA * 93309
661-631-0750

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and when a Chiropractor accepts a patient for such care, it is essential that they are both seeking and working for the same goals.

Chiropractic has only one goal. It is, therefore, important that the patient understands the goal and the means and methods that will be used to attain it. In this way, there will be no confusion, misunderstanding, nor disappointment.

Patients usually are only interested in getting rid of whatever ailment or condition that is bothering them. This, however, is **not** the goal of the Chiropractor.

The purpose of Chiropractic is to restore and maintain the mechanical integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignments of the vertebrae or bones of the spine which interfere with the function of these nerve pathways are called **SUBLUXATIONS.** They come from many causes and prevent various organs and glands from working properly.

By means of a Chiropractic adjustment, **SUBLUXATIONS** are corrected, thus restoring normal nerve function. The goal of chiropractic is too correct **vertebral subluxations** for the purpose of restoring the proper transmission of nerve energy over the nerve pathways, so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

With proper nerve supply, health improves. Often, symptoms clear up; sometimes quickly- sometimes slowly- sometimes only partially- or not at all. Regardless of what disease a patient may or may not have, a Chiropractor does not offer to cure it, treat it, or offer advice regarding it. The only goal of Chiropractic is to allow the body to better express its own innate health potential. The only method used is the correction of the **vertebral subluxation.**

PLEASE BE AWARE THAT BY SIGNING YOUR NAME ON THIS FORM, YOU AGREE TO FOLLOW ALL INSTRUCTIONS THE DOCTOR GIVES YOU IN ORDER TO AFFECT THE GREATEST RECOVERY THAT IS POSSIBLE.

MUTUAL COOPERATION BETWEEN YOU AND THE DOCTOR IS A VERY NECESSARY PART OF YOUR RETURN TO GOOD HEALTH!!!

Patient's signature_____ Date_____

BAKERSFIELD FAMILY CHIROPRACTIC

3900 Truxtun Ave. Bakersfield, CA 93309
661.631.0570

Thank you for selecting us.

To help us meet all you healthcare needs, please read this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

WELCOME

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies please discuss them with our office. We are dedicated to providing the best possible care and service to you, and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless either you or your health insurance carrier has made other arrangements in advance, full payment is due at the time of service. For your convenience we accept VISA, MasterCard and Discover.

- ☐ The patient understands and agrees by his/her signature agrees upon the charges for professional services provided by Perry Chiropractic, Inc.
- ☐ Although you are responsible for the entire balance at the time of service, it is our office policy to bill your insurance carrier as a courtesy to you. We do require that your co-payment or deductible, if applicable, be paid at the time of service.
- ☐ Our fees are considered as usual, customary and reasonable fees based on the (RVU) of the Bakersfield city area. Some insurance companies set their own (UCR) fees, which may not be the same as our fees.
- ☐ The patient further understands and agrees that if the balance due is not paid in full within 60 days from the date of service, there will be a billing charge of 1.5% per month or 18% per annum until the outstanding balance is paid in full.
- ☐ If the account is assigned to collections, the patient will be responsible for the entire account balance owed plus any collection and reasonable attorney fees.

Patient/Guardian Signature_____ Date_____

Witness Signature_____ Date_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR AND PRIVATE GROUP ACCIENDENT AND HEALTH INSURANCE

RE:
Patient: _____
Employer: _____
Claim/Group # _____
SS#/ID# _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assigument shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____ 20____.
City, State — Date — Month — Year

_____ _____
Signature of Policyholder — Witness

_____
Signature of Claimant, if other than Policyholder

Bakersfield Family Chiropractic

Dr. William E. Perry
Dr. Stephanie M. Perry

Privacy Notice Consent

All California chiropractic patients are protected by the Health Insurance Portability and Assurance Act or (HIPAA). Passed by the US Congress in 1996, about a third of the Act deals with the privacy of your personal health information.

- You have the right to review and copy your own health information
- You have the right to request changes to your health records
- You have the right to request privacy protection for your health records
- You have the right to obtain an accounting of your personal health information
- disclosures
- The individual has the right to receive written notice of a covered entity's policies
- regarding privacy
- You have the right to consent to allow your personal health information to be used for the
- core functions of treatment, payment and health care operations
- You have the right to consent to allow your personal health information to be used or
- disclosed for other functions (authorization)
- You have the right to agree or object to certain limited disclosures of your personal health
- information

Most of this is common courtesy. Relax, knowing that California chiropractors, like all doctors, keep your health information private and protected.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Tatsuno Chiropractic, Inc. with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care information as described in the privacy notice.

_____ _____

Name (Print) Date

_____ _____ _____

Patient Signature Authorized Facility Signature Date

Informed Consent to Chiropractic Treatment

Bakersfield Family Chiropractic
3900 Truxtun Avenue
Bakersfield, CA 93309
661-631-0570
Dr. William E. Perry & Dr. Stephanie M. Perry

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Witness Signature

_____

Date

Tatsuno, Pedersen, Kinoshita, Perry & Huynh Chiropractic Offices

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Text Message

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked Start Date:_____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Religion:_____

Family Medical History

Family Medical History *(Record one diagnosis in your family history and the affected relative)*				
Health Condition (Write in below)	Father	Mother	Sibling: (Brother/Sister)	Offspring: (Son/Daughter)

Mothers Maiden Name: First:	Last:
Next of Kin:	Relationship:
Address:	City State:
Phone:	

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)* ***You can request copies at any time.***

Patient Signature: _____ Date: _____