Referred By: _____

Chiropractic & Massage Health Questionnaire

Name: _____Date of Birth: _____ Age: _____ Phone (H)_____ (W)_____

Address: _____City:_____ State: _____ Zip: _____ E-mail: _____

Employer: _____Occupation:_____ Years Employed: _____ Hours worked/week_____

Social Security: _____ Marital Status: S M D W Partner: _____

Children: No Yes Name/s and Age/s:_____
Have you had previous chiropractic care? No Yes _____ Has your family had chiropractic care? No Yes

Rate your current health habits: Nutrition GOOD FAIR POOR Do you drink? Yes No
(circle which applies) Sleep Habits GOOD FAIR POOR Do you smoke? Yes No
Exercise GOOD FAIR POOR Drink coffee? Yes No
Stress GOOD FAIR POOR Take Drugs? Yes No

Rate your current health: GREAT GOOD OKAY POOR Your Family's: GREAT GOOD OKAY POOR
(circle which applies)

Do you presently have any health problems or major complaints? ☐ No ☐ Yes Explain: _____

_____

How long have you had this? _____ It interferes with ☐ work ☐ home ☐ family ☐ sleep ☐ sex ☐ sports

What makes it worse? _____ Better? _____

Previous care for this condition? ☐ No ☐ Yes Explain _____

Is this condition getting better or worse? ☐ No ☐ Yes Explain _____

At its worst, how does it feel? _____ Do you want to get rid of this condition? ☐ No ☐ Yes

CHECK ANY OF THE MUSCULO/SKELETAL SYSTEM THAT APPLIES:

☐ Neck Pain ☐ Shoulder Pain ☐ Arm Pain ☐ Upper Back Pain ☐ Mid Back Pain ☐ Headaches
☐ Low Back Pain ☐ Hip Pain ☐ Leg Pain ☐ Jaw Clicking ☐ Walking Difficulty ☐ Jaw Pain
☐Tingling ☐ Burning Pain ☐ Numbness ☐ Dull Aches ☐ Breathing Difficulty ☐ Joint Pain
☐ Fracture ☐ Spinal Fusion ☐ Disc Problems ☐ Bone Deformities ☐ Dislocations ☐ Arthritis

CHECK ANY OF THE FOLLLOWING DISEASES OR ORGAN PROBLEMS YOU HAVE HAD:

☐ Bladder Trouble ☐ Painful Urination ☐ Excessive Urination ☐ Discolored urine ☐ Kidney Stones
☐ Shortness of Breath ☐ Chest Pain ☐ High Blood Pressure ☐ Irregular Heart Beat ☐ Difficult Breathing
☐ Varicose Veins ☐ Ankle Swelling ☐ Constipation/Diarrhea ☐ Bloating/Gas ☐ Nausea/vomiting
☐ Prostate Problems ☐ Impotence ☐ Menstrual Pain/cramps ☐ Menopause ☐ Pregnancy
☐ Asthma ☐ Stroke ☐ TB ☐ Diabetes ☐ Epilepsy
☐Cancer ☐ Anemia ☐ Seizures ☐ Mental Disorder ☐ Heart Disease
☐ Thyroid ☐ Eczema ☐ Aids ☐ Dizziness ☐ Liver Disease
☐ Paralysis ☐ Hemorrhoids ☐ Gall Stones ☐ Prostate ☐ Allergy

List all medications: _____

Prior accidents? ☐ No ☐ Yes (list)_____

Prior surgeries? ☐ No ☐ Yes (list) _____

(CONTINUED ON OTHER SIDE)

VanQuaethem Chiropractic Maui ● P.O. Box 12642 Lahaina, HI 96761

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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 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 a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that 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.

_____ _____
Signature Date