

Young Chiropractic & Rehabilitation Center  
Peter K. Young, D.C. Chiropractic Questionnaire  
Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Cell Phone Carrier:** Sprint Verizon AT&T Boost **Preferred Contact:** Home Cell

Email Address \_\_\_\_\_

Would you like to receive our newsletter and special offers and events through email? Y N

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Status: S M D W

How were you referred to our office? \_\_\_\_\_, May we thank them? Yes No

Primary Physician \_\_\_\_\_ Telephone Number \_\_\_\_\_

Do we have permission to contact your primary physician about your care here? Yes No

Current Employer \_\_\_\_\_ Telephone Number \_\_\_\_\_

Employment Status: Part Time Full Time Other

Emergency Contact & Relationship \_\_\_\_\_ Telephone Number \_\_\_\_\_

**Health Insurance Information:**

Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

**If your visit is in relation to an auto accident or a work related injury, please provide the following:**

Auto/Worker's Compensation Insurance Company: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Claim Number: \_\_\_\_\_

I instruct Young Chiropractic & Rehabilitation Center to bill and remit payment from the above medical/liability insurance for all services rendered to me after each visit as a direct assignment of my rights and benefits under this policy. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct my medical/liability insurance to make out the check to Young Chiropractic and mail it the 9825 Giles Rd, Suite F, La Vista, NE 68128. In the event that the above liability does not pay; Young Chiropractic & Rehabilitation Center has the right to bill the above medical insurance for payment on my account. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. \* I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I have provided all the necessary billing information to Young Chiropractic & Rehabilitation Center to ensure prompt payment and by signing this I am agreeing to update Young Chiropractic immediately with any changes.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I give permission to use my name in your patient newsletter and on any office bulletin or other notice boards for purposes of announcements and acknowledging my referrals.

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Name \_\_\_\_\_ Date \_\_\_\_\_

1. What is your major symptom? \_\_\_\_\_

2. What does this prevent you from doing or enjoying? \_\_\_\_\_

3. If this is a recurrence, when was the first time you noticed the problem? \_\_\_\_\_

How did it originally occur? \_\_\_\_\_

Has it become worse recently?    Yes    No    Same    Better    Gradually Worse

Explain \_\_\_\_\_

How would you rate your pain?    1    2    3    4    5    6    7    8    9    10 (with 10 being the worst)

4. How frequent is the condition?    Constant    Daily    Intermittent    Night Only

How long does it last?    All Day    Few Hours    Minutes

When is it worse?    Morning    Evening    As the Day Progresses    No Change

5. Are there any other conditions or symptoms that may be related to your major symptoms?

Explain \_\_\_\_\_

a) Are there any other unrelated health problems?    Yes    No

Explain \_\_\_\_\_

6. Describe the pain: \*Sharp \*Dull \*Numbness \*Tingling \*Aching \*Burning \*Stabbing

\*Other: \_\_\_\_\_

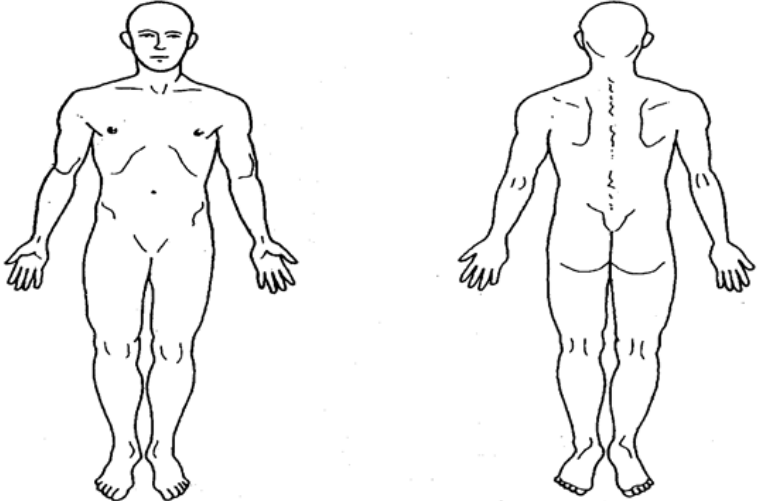
7. Is there anything you can do to relive the problem?    Yes    No    Explain \_\_\_\_\_

8. What makes the problem worse? \*Standing \*Sitting \*Lying \*Bending \*Lifting \*Twisting

\*Other \_\_\_\_\_

9. List any major accidents you have had other than those that might have been mentioned:

\_\_\_\_\_

	<p style="text-align: center;"><b>Please show me where your symptoms are and the type of problems you are having using the following guide:</b></p> <p>&gt;&gt;&gt;    <b>Pain</b></p> <p>~ ~ ~    <b>Pins and Needles</b></p> <p>///    <b>Burning</b></p> <p>000    <b>Throbbing</b></p> <p>^^^    <b>Sore</b></p> <p>###    <b>Aching</b></p>
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Name \_\_\_\_\_ Date \_\_\_\_\_

<b>Personal Health History</b>		
<b>List any medical problems that other doctors have diagnosed:</b>		
<input type="checkbox"/> Hypertension <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Neuropathy <input type="checkbox"/> Stroke <input type="checkbox"/> Brain Tumor <input type="checkbox"/> Epilepsy <input type="checkbox"/> Depression <input type="checkbox"/> Dementia <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Chronic Back Pain <input type="checkbox"/> Other:		
<b>List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:</b>		
Name of the Drug	Strength	Frequency Taken
<b>Allergies to Medications:</b>		
Name of the Drug	Reaction You Had	
<b>Surgeries/Hospitalizations</b>		
Year	Reason	Hospital
Childhood Illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	

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Past Tests:	<input type="checkbox"/> Angiocath <input type="checkbox"/> Cardio Echo <input type="checkbox"/> CT scan <input type="checkbox"/> Blood Work <input type="checkbox"/> Cultures <input type="checkbox"/> Ultrasound <input type="checkbox"/> MRI <input type="checkbox"/> Biopsies <input type="checkbox"/> X-rays <input type="checkbox"/> NCV <input type="checkbox"/> EMG
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Date of last Physical Exam: \_\_\_\_\_

Family Health History					
Relative	Age	Cause of Death/Health Problems	Relative	Age	Cause of Death/Health Problems
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M		Grandmother (Maternal)		
	<input type="checkbox"/> F				
	<input type="checkbox"/> M		Grandfather (Maternal)		
	<input type="checkbox"/> F				
	<input type="checkbox"/> M		Grandmother (Paternal)		
	<input type="checkbox"/> F				
	<input type="checkbox"/> M		Grandfather (Paternal)		
	<input type="checkbox"/> F				

Social History	
<b>Marital Status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated
<b>Household</b>	<input type="checkbox"/> Live Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> With _____
<b>Alcohol</b>	<input type="checkbox"/> None <input type="checkbox"/> Casual (<5/week) <input type="checkbox"/> Moderate (5-10/week) <input type="checkbox"/> Heavy (>10/week)
<b>Caffeine</b>	<input type="checkbox"/> <3 drinks/day <input type="checkbox"/> 3-6 drinks/day <input type="checkbox"/> >6 drinks/day
<b>Tobacco</b>	<input type="checkbox"/> Never <input type="checkbox"/> Casual Smoker <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Chewing Tobacco
<b>Drugs</b>	Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you used recreational or street drugs in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Exercise</b>	<input type="checkbox"/> None <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Walks <input type="checkbox"/> Runs <input type="checkbox"/> Swims
<b>Occupation</b>	<input type="checkbox"/> Student <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired Occupation: _____

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<b>Review of System</b>	
Have you recently suffered from any of the following symptoms?	
General	<input type="checkbox"/> Weight Change <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Weakness
Head	<input type="checkbox"/> Headache -Location _____ -Frequency _____ <input type="checkbox"/> Trauma to Head
Eyes	<input type="checkbox"/> Blurriness <input type="checkbox"/> Tearing <input type="checkbox"/> Recent Vision Loss
Ears	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Vertigo/Dizziness
Respiratory	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing
Cardiac	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Murmurs <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest Pain
GI	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in Stool
Vascular	<input type="checkbox"/> Swelling in Legs <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Leg pain with walking
MS	<input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Problems Balancing <input type="checkbox"/> Joint Pain <input type="checkbox"/> Gout
Neuro	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Fainting <input type="checkbox"/> Seizers
Endocrine	<input type="checkbox"/> Increased Thirst <input type="checkbox"/> Increased Urination <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Diabetes
Psych	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> High Stress <input type="checkbox"/> Memory Loss

**Pregnancy Waiver**

I hereby acknowledge that Dr. Peter K. Young D.C. of Young Chiropractic and Rehabilitation Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

\_\_\_\_\_  
Signature of Patient/Authorized Representative of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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**Consent for Care**

I, \_\_\_\_\_, in coming to the Chiropractic Physician, give the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplication health care service. Your Doctor of Chiropractic is licensed in a special practice, and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Young Chiropractic & Rehabilitation Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

\_\_\_\_\_  
Signature of Patient/Authorized Representative of Patient

\_\_\_\_\_  
Date

**Patient Acknowledgement and Receipt of Notice of Privacy  
Practices Pursuant to HIPPA 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 Pursuant To HIPPA and has been advised that a full copy of this office's HIPPA Compliance Manual is available upon request.

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

\_\_\_\_\_  
Signature of Patient/Authorized Representative of Patient

\_\_\_\_\_  
Date

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**What to Expect after your first Adjustment**

**Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.**

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is normal reaction to chiropractic adjustments.
2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 30 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.
3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.
4. Stay away from heavy lifting, or repetitive movements, until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects, such as groceries, pets, and children, and any other activities that could aggravate or re-injure your condition.
5. Unless indicated by the doctor, you may return to work/school after your appointment.
6. If a sudden movement causes sharp or severe pain, or if you experience swelling, contact the clinic at 402-339-2283. If after hours, please leave a message and we will return your call during business hours. If it is an emergency, please go to the emergency room, or call 911.

I have read and understand the instructions given for my follow-up care.

\_\_\_\_\_  
Signature of Patient/Authorized Representative of Patient

\_\_\_\_\_  
Date