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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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

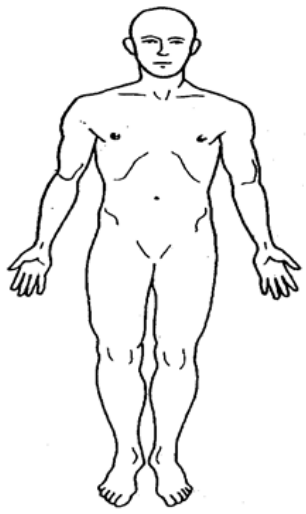
      Explain_____
6. Describe the pain: *Sharp *Dull *Numbness * Tingling *Aching *Burning *Stabbing

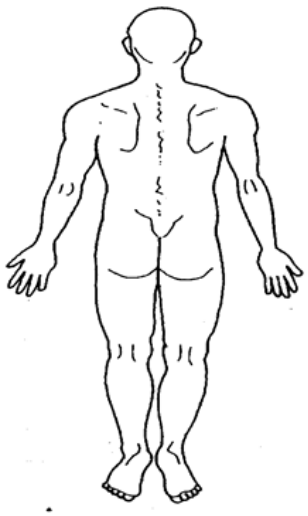
   *Other: _____
7. Is there anything you can do to relive the problem? Yes No Explain _____

   _____
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:

   _____





Please show me where your symptoms are and the type of problems you are having using the following guide:

>>>	**Pain**
~ ~ ~	**Pins and Needles**
///	**Burning**
000	**Throbbing**
^^^	**Sore**
###	**Aching**

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

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Past Tests:	□ Angiocath □ Cardio Echo □ CT scan □ Blood Work □ Cultures □ Ultrasound □ MRI □ Biopsies □ X-rays □ NCV □ EMG
Date of last Physical Exam:	

Family Health History

Relative	Age	Cause of Death/Health Problems	Relative	Age	Cause of Death/Health Problems
Father			Children	□ M □ F	
Mother				□ M □ F	
Sibling	□ M □ F		Grandmother (Maternal)		
	□ M □ F		Grandfather (Maternal)		
	□ M □ F		Grandmother (Paternal)		
	□ M □ F		Grandfather (Paternal)		

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

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