FAMILY HEALTH
CHIROPRACTIC, PC
Healthy Families by Choice, not by Chance

Dr. John Badinger
117 East Century Ave
Bismarck, ND 58503
(701)258-7047
chooseFAMILYHEALTH@gmail.com

Confidential Young Adult Patient Information

Name_____ Home#

_____

Address_____ City/State _____

Zip_____

Age _____ Birth Date _____School _____ Grade_____

E-mail _____ Cell# _____

Father **Previous Chiropractic Care** Y/N Why?

_____

Name_____ Age_____ Birth Date

_____ Address_____ City/State

_____ Zip_____

Employer_____ Business#

_____

E-Mail_____

Home#_____Cell#_____

Mother **Previous Chiropractic Care** Y/N Why?

_____

Name_____ Age_____ Birth Date

_____ Address_____ City/State

_____ Zip_____

Employer_____ Business#

_____

E-Mail_____

Home#_____Cell#_____

Sibling's Information **Previous Chiropractic Care**

Sibling #1 Name_____ Age____ Birth Date_____ Y/N Why?

_____

Sibling #2 Name_____ Age____ Birth Date_____ Y/N Why?

_____

Sibling #3 Name_____ Age____ Birth Date_____ Y/N Why?

_____

Sibling #4 Name_____ Age____ Birth Date_____ Y/N Why?

_____

Other Siblings Names and DOB's

_____

Who Can I Thank for Referring You:

_____

Circle the phrase that most represents your reason for care:

◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Reason for your child seeking services at our office: _____

Has you ever seen a Chiropractor? ◯ Yes ◯ No If yes, who? _____

Date of last visit:_____

Name & Address of Primary Health Care Provider:

_____

_____

Date of last visit _____ Purpose of visit _____

Current Drugs/Medications? _____

_____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

What is the pain like for each area? (Example- dull, sharp, stabbing, shooting, numb, etc) Does it radiate anywhere Please describe in your own words?

_____

_____

_____

_____

_____

_____

_____

_____

Since the problem started its: Same?☐ Getting Better?☐ Getting Worse?☐

What have you done for this condition? Did it make it better or worse?

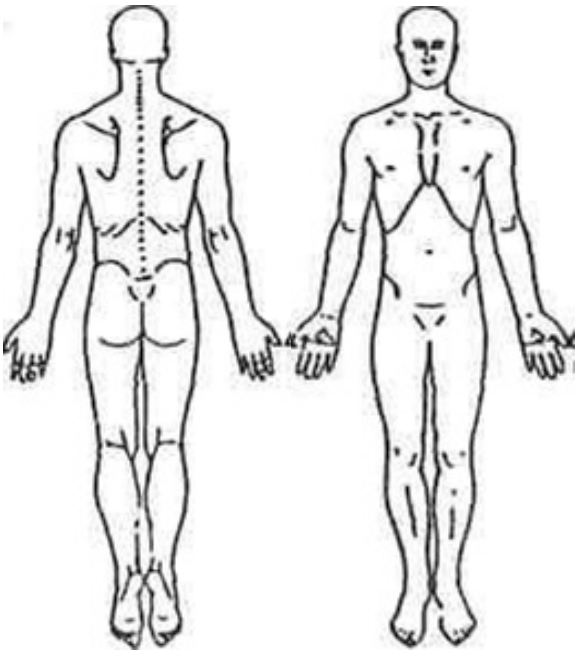
_____

_____

_____

_____

_____



Color Any Areas
You are having a complaint.

Which activities aggravate your condition? What makes it better?

I do (do not) have a family history of this or similar symptoms (Please explain):

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, sports, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐

3. Type:	When?	Hospitalized? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Past & Curent Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐ Multiple Sclerosis	☐ Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐ Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain)

Informed Consent and Terms of Acceptance for Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct and help prevent subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

Adjustment: An adjustment is a specific application of energy to facilitate the body's correction of a subluxation. Our method of correction is by specific Chiropractic adjustments of the neuro-muscular-skeletal system either by hand or instrument.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that everybody has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional symptoms. Our expertise is in health, wellness, healing and human physiology and how it has adapted to lifestyle stresses. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of subluxations and the promotion of genetically congruent human lifestyle choices.

At this office, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

(Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroid Anti-inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995)

I, _____ have read and fully understand the above statements.
(PRINT NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. John Badinger or other attending chiropractor.

_____ _____
(SIGNATURE) (DATE)

Consent to assess and care of a minor:

I, _____, being the parent or legal guardian of
(PARENT/GUARDIAN NAME)

_____ have read and fully understand the above terms of acceptance and
(CHILD'S NAME)
hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

_____ _____
(SIGNATURE) (DATE)