

Adult Patient Questionnaire

Confidential Patient Information

First Name:

Last Name:

Date:

SSN:

DOB:

Sex:

Occupation:

of Children:

Marital Status:

Street Address:

Height:

City, State, Postal Code:

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 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?

Please indicate where you are experiencing pain or discomfort.

X = Current condition; O = Past condition

Have you received care for this problem before? Yes No

– If yes, please explain:

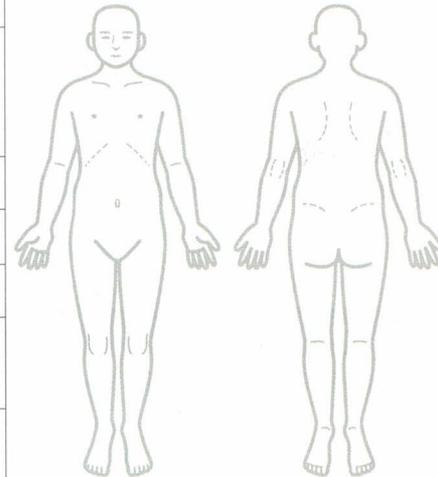
When did the condition(s) first begin?

How did the problem start? Suddenly Gradually Post-Injury

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?



Your Health Goals

What are your top three health goals?

1. _____

2. _____

3. _____

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 Nutrition 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 past auto accidents? Yes No – If yes, please explain:

How often do you exercise? None 1-3x per week 4-6x 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 do you typically spend sitting at a desk? _____ On a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None					Moderate					High				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Alcohol	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Water	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Sugar	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Dairy	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Gluten	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Processed Foods	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Artificial Sweeteners	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Sugary Drinks	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Cigarettes	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Recreational Drugs	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs or other that you are taking and why:

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None					Moderate					High				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Home	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Work	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Life	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Money	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Health	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Family	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Acknowledgement & Consent

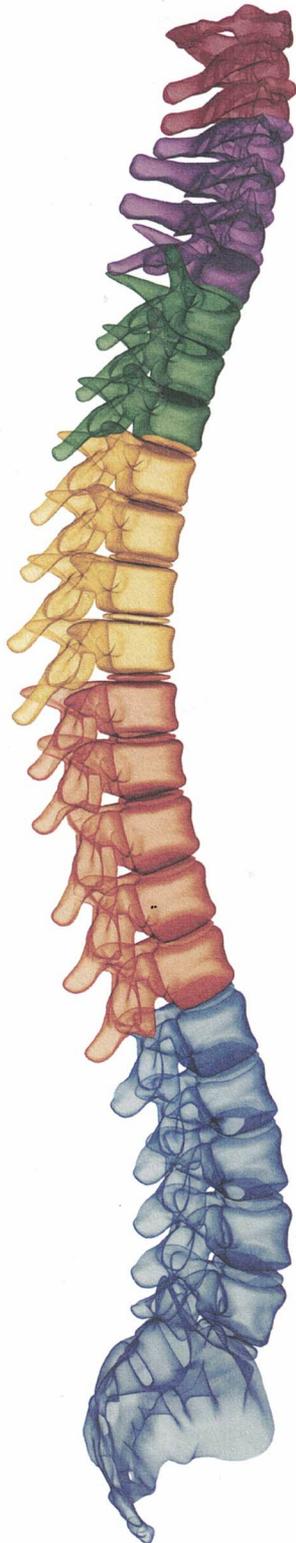
Patient Signature: _____

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

Patient Name: _____ Date: _____

Automated Text Reminder Consent

Your health is important to us. To help provide you with the best possible care, we send automated text appointment reminders to our patients with the upcoming date and time.

I, _____, give Maple Lake Chiropractic permission to send out text
(Print Name)

reminders for all my future appointments unless otherwise stated.

Signature

Date

Patient's Cell Phone Number: _____

We look forward to providing better and more convenient communications with you via messaging. Our goal is to provide you with the tools to keep your care on track. Thank you!

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowingly give or withhold your consent.

Chiropractic is based on science which concerns itself with the relationship between structures and function, and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A **chiropractic examination** will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination, and laboratory testing.

The **chiropractic adjustment** is the application of a precise movement and/or force into the spine to reduce or correct vertebral subluxation(s). There are several different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

Risks associated with chiropractic treatment may include soreness, musculoskeletal sprain/strain, or fracture. Risks associated with physiotherapy may include allergic reactions or muscle and joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke, rather, recent studies indicate that patients may be consulting with MDs and DCs when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including that care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE, MAPLE LAKE CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED _____

Patient's Signature

Doctor's Signature

Parental Consent for Minor Patient

Patient Name: _____

Patient Age: _____ DOB: _____

Printed Name of person legally authorized to sign for:

Name: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for:

Name: _____

Signature: _____

Relationship to Patient: _____

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or cell phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting Dr. Brittany Gregory 269-655-2100
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care or payment for your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

If we have your substance use disorder patient records, subject to 42 CFR part 2, we will give you clear and obvious notice in advance and a choice about whether to receive fundraising communications that use your Part 2 information.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

In all cases, including those listed below, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This Notice is Effective 02/16/2026 and Applies to the Organizations Below

Maple Lake Chiropractic

109 W. Michigan Ave

Paw Paw, MI 49079

I do hereby acknowledge receipt of a copy of the Notice, Privacy Practices, Policies, and Procedures:

Patient Signature

Date

Guardian Signature

Date