

NEW PATIENT INFORMATION QUESTIONNAIRE

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. In order to understand your condition properly, please be as neat and accurate as possible while completing this form. **Please answer all questions completely.** Thank you!

Patient: _____ Soc.Sec.No. _____
(First) (Middle) (Last)

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Birth Date: _____ Home PH# _____

Female: Are you pregnant? _____ Numbers & ages of children: _____ Cell# _____

Home Address: _____
(Street) (City) (State) (Zip) **(No P.O. Boxes Please)** E-Mail Address _____

Patient Employed By: _____ Occupation: _____

Business Address _____ Business Phone _____
(Street) (City) (State) (Zip)

Name of Spouse: _____ Soc. Sec. No. _____

Spouse Employed By: _____ Business Phone _____

List the name, address and phone numbers of two relatives not living with you: _____

EMERGENCY CONTACT: _____

Were you referred by one of our patients or another doctor? _____ Who? _____

Who is responsible for this account? _____

What are your main problems (Pains)? _____

What other health care have you received for this problem? _____

Date of Accident/Beginning of Illness: _____

Location of Accident: _____

How did it occur? ___ Auto Collision ___ On the Job ___ Other _____

Please describe the circumstances: _____

Have you lost time from work? ___ Dates: _____

Is this case covered by insurance? _____ Please indicate which kind of insurance you have:

Group Insurance ___ Blue Cross/Blue Shield ___ Blue Choice ___ Medicare ___ Auto ___

Insurance ___ Worker's compensation ___ Personal Injury ___ Other Insurance ___

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST TO BE PHOTOCOPIED:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, **I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Signature: _____ Date: _____

(If patient is a minor, name of parent or guardian.)

HEALTH QUESTIONNAIRE

Using one of these codes: **(1) Previously Had** **(2) Presently Have** please answer the following questions.

Patient Name _____

Date _____

CARDIOVASCULAR SYSTEM

- Angina
- Blood
- Cold extremities
- Light headed
- Heart murmur
- Heart problems
- Leg pain with walking
- Low blood pressure
- High blood pressure
- Swollen ankles

RESPIRATORY SYSTEM

- Asbestos exposure
- Asthma
- Chronic cough
- Coughing blood
- Labored breathing
- Dry cough
- Painful breathing
- Productive cough
- Shortness of breath
- Wheezing

MUSCULOSKELETAL SYSTEM

- Back pain
- Neck Pain
- Pain between shoulders
- Swollen joints
- Painful joints
- Foot cramps
- Leg cramps
- Muscle pain
- Muscle twitching
- Muscle weakness
- Back injury
- Neck injury
- Broken bones

NERVOUS SYSTEM

- Confusion
- Convulsions
- Speech difficulties
- Dizziness/Vertigo
- Double vision
- Fainting
- Forgetfulness
- Headaches
- Incoordination
- Memory loss
- Twitching
- Tics
- Numbness/Tingling
- Paralysis
- Seizures

EARS, NOSE, & THROAT

- Bleeding gums
- Cold sores
- Dental Problems
- Deviated septum
- Difficulty swallowing
- Ear discharge
- Ringing in ears
- Ear pain
- Hearing loss
- Motion sickness
- Nasal drip
- Nasal polyps
- Recurring nose bleeds
- Ear infections
- Sinus infections
- Sinus pain
- Tonsillitis
- Vertigo/Dizziness
- Diminished Smell

EYES

- Injury to eyes
- Blurred vision
- Crossed Eyes
- Recurring dry eyes
- Glaucoma
- Recurring itchy eyes
- Recurring redness
- Recurring tearing

SKIN

- Moles
- Acne
- Boils
- Bruise easily
- Corns
- Excessive dryness
- Excessive perspiration
- Hives
- Itching
- Nail Fungus
- Warts
- Psoriasis
- Rashes
- Eczema

GASTRO-INTESTINAL SYSTEM

- Excessive gas
- Abdominal pain
- Acid reflux
- Excessive belching
- Black stools
- Recurring constipation
- Recurring diarrhea
- Difficulty swallowing
- Nausea
- Frequent vomiting
- Heart burn
- Hemorrhoids
- Need laxatives
- Stomach ulcers
- Vomiting blood
- Bloody stools

GENITO-URINARY SYSTEM

- Bedwetting
- Loss of bladder control
- Discolored urine
- Frequent urination
- Kidney stones
- Urgent Urination
- Painful urination

FEMALE

- Yeast infections
- Heavy menstruation
- Hot flashes
- Irregular periods
- Menstrual cramps
- Painful intercourse
- Breast pain
- Lumps in breast
- Diminished sex drive
- Painful discharge

MALE

- Difficulty with intercourse
- Impotency
- Inguinal hernia
- Testicular lumps
- Painful genitals
- Prostate hypertrophy
- Sore genitalia

ENDOCRINE SYSTEM

- Loss of appetite
- Recurring fatigue
- Nervousness
- Excessive hunger
- Excessive thirst
- Diabetes
- Weight gain
- Weight loss
- Cold intolerance

CONSTITUTIONAL

- Reoccurring chills
- Reoccurring fever
- Frequent fatigue
- Night sweats
- Memory trouble
- Nausea
- Nervousness
- Weakness
- Weight Change
- Dizziness

PSYCHIATRIC

- Depression
- Alcoholism
- Anxiety
- Emotional Stress
- Drug Addiction
- Nervous eating
- Irritability
- Excessive worrying
- Hyperventilation
- Hallucinations
- Nail biting
- Phobias
- Nightmares
- Sleep walking

Diagnosis & Diseases

Patient Name: _____ Date: _____

Childhood Diseases: Measles Mumps Whooping Cough Chicken Pox Rheumatic Fever Fractures
 Asthma Diabetes Other: _____

Adult Diseases: Tuberculosis Diabetes Hypertension Heart Attack Stroke Cancer Fractures
 HIV/AIDS Other: _____

Surgeries- Dates, Hospitals, Diagnosis, & Complications _____

Medications- Dosage & Frequency: _____

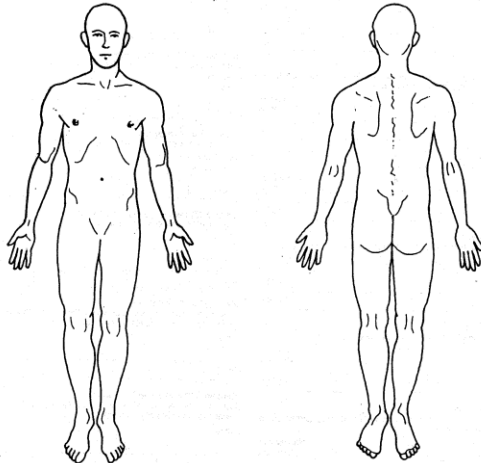
Allergies: (Ex: Medications, Environmental, Food, Latex, Dairy, Penicillin) _____

Do you currently smoke? Y or N Packs per day? _____ How long have you smoked? _____

If no, did you previously smoke? Y or N Packs per day? _____ How long ago did you quit? _____

Do you currently use chewing tobacco? Y or N If no, have you previously used chewing tobacco? Y or N

Please place an X over the area where you are having difficulty.



Occupation and Recreational History

Name _____ Date _____

How long have you been employed there? _____

List ALL limitations at work as a result of injuries? _____

Your present job involves and how long in hours? _____

Standing Driving Walking Sitting Lifting Typing Using a mouse Grasping Crawling Climbing Repetitive motion

Fine manipulations, pushing, pulling or torquing of hands

Date of full last day of work? _____

Have you lost any work as a result of your condition? Y or N How many days? _____

How many rest breaks does the patient receive? _____

% work day indoor? _____ % work day outdoors? _____

Type of surface patients works on?

Asphalt Gravel Pavement Carpet Wood Concrete floors Grass Dirt
 Uneven surfaces

You are required to:

Work heights Walk on uneven surfaces Drive Vehicles
 Operate hazardous equipment Work near hazardous equipment?

Since your injury have you been pressured for speed, perfection or performance?

Constant Frequently Intermittent Occasional

Since your injury what is your job performance?

Excellent Very Good Good Acceptable Mediocre Poor

Please list all recreational activities _____

Please tell us how often you exercise? _____

What kind of exercise do you do? _____

Do you have a well balanced diet? Y or N

How many hours a day do you sleep? _____

Do you participate in sports? Y or N How often? _____

If so, what sports? _____

Are you involved in hobbies? Y or N How often? _____

If so, what hobbies? _____

Do you travel internationally? Y or N

Have you served in the military? Y or N

If so, what branch? Army Air Force Marines Navy Coast Guard

War time service Y or N

Did you suffer trauma from the war? Y or N