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 QUESTIONANAIRE

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

Patient Name _____ Date _____

CADRIOVASCULAR 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:_____
_____
_____

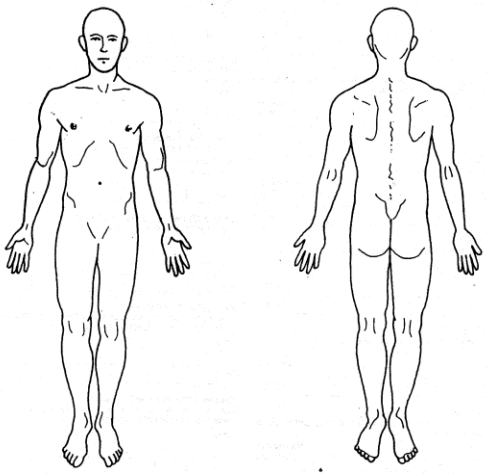
Surgeries- Dates, Hospitals, Diagnosis, & Complications_____
_____
_____
_____
_____
_____

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 torqeuing 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