ELITE SPINE AND SPORT CENTER

# CHIROPRACTIC HEALTH QUESTIONNAIRE

Name:____________________________________ SS#: ___________________ Today's Date: _____/_____/_____

Address:____________________________________________ City: ___________________

State: _______ Zip:____________

What you prefer to be called: ________________ Age: _________ Birthdate: _____/_____/_____

Handedness: __________ Height: ___________ Weight: ____________ Number of Children: _______

☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse: __________________

Home Phone: _______________________ Cell Phone: _______________________ Carrier:_____________

Work Phone: _______________________ E-Mail Address: ________________________

Occupation: ____________________________ Employer: ________________________________________

Referred By: __________________________________

**Are you currently taking any medication?** ☐ Muscle Relaxants ☐ Blood Thinners ☐ Insulin ☐ Stimulants ☐ Tranquilizers ☐ Pain Killers ☐ Other(s)______________________

**Have you ever had any of the following diseases or medical conditions?**

| | | | | |
|---|---|---|---|---|
| ☐ Arthritis | ☐ Asthma | ☐ Sinus Trouble | ☐ Joint Replacement | ☐ Allergies |
| ☐ Tuberculosis | ☐ Diabetes | ☐ Epilepsy | ☐ Thyroid Trouble | ☐ High/Low BP |
| ☐ Emphysema | ☐ Ulcer / Colitis | ☐ Cancer | ☐ Polio | ☐ Rheumatic Fever |
| ☐ Emotional Disorders | ☐ Bone Fracture | ☐ Multiple Sclerosis | ☐ Prostate Trouble | ☐ Kidney Disease |
| ☐ HIV + | ☐ Heart Attack | ☐ Stroke | ☐ Hepatitis | ☐ Anemia |
| ☐ Neck Pain | ☐ Low Back Pain | ☐ Headaches | ☐ STD's | ☐ Joint Pain |

Please list any other notable conditions that you had / have____________________________________________

Family history of any of the previous or other? ☐ Yes (please note_________________________________) ☐ No

**What are your habits?**

| | | | | |
|---|---|---|---|---|
| Smoking | ☐ Never | ☐ Occ | ☐ Moderately | ☐ Excessively |
| Alcohol | ☐ Never | ☐ Occ | ☐ Moderately | ☐ Excessively |
| Recreational Drugs | ☐ Never | ☐ Occ | ☐ Moderately | ☐ Excessively |
| Exercise | ☐ Never | ☐ Occ | ☐ Moderately | ☐ Excessively |

List any previous surgeries/hospitalizations and dates_________________________________________________

Are you wearing any: ☐ Heel lifts ☐ Inner soles ☐ Arch Supports What is the age of your mattress?__________

**For Women:** Are you taking birth control? ☐ Yes ☐ No Are you pregnant? ☐ Yes (How many mo._____) ☐ No

Date of your last period?____________ Are you under the regular care of an OB/GYN? ☐ Yes ☐ No

Was your accident directly related to your **work**? ☐ Yes ☐ No **If no, continue to next section please.**
Date & Time of Accident:_________________
Briefly describe the events that occurred just before and during your accident: ________________________________
____________________________________________________________________________________________________
Give the address where the accident occurred (if other than the employer's address): __________________________
____________________________________________________________________________________________________
Was anyone else present during your accident ☐ Yes ☐ No
Did you report your accident to your employer? ☐ Yes ☐ No
What recommendations did your employer make just after your accident? __________________________________
____________________________________________________________________________________________________
Has this type of accident happened to you before? ☐ Yes ☐ No
To the best of your knowledge, has this accident occurred in your workplace before? ☐ Yes ☐ No
In general:

- Is your job physically stressful? ☐ Yes ☐ No
- Is your job mentally stressful? ☐ Yes ☐ No
- Is your workplace noisy? ☐ Yes ☐ No
- Have you changed jobs in the last year? ☐ Yes ☐ No

Date & Time of **Auto** Accident:________________________ Location: ______________________________________
Were you the: ☐ Driver ☐Front Passenger ☐ Rear Passenger
If a traffic violation was issued, to whom was it issued? ______________________________________________

How did the accident occur? ________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Number of people in accident vehicle? _________
Did the police come to the scene? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No
Were there any witnesses? ☐ Yes ☐ No Were you wearing your seat belt? ☐ Yes ☐ No
Was this vehicle equipped with airbags? ☐ Yes ☐ No If yes, did they inflate? ☐ Yes ☐ No

What was the approx. speed of your vehicle? ________
Did the impact come from the: ☐ Front ☐ Rear ☐ R side ☐ L side ☐ Other
During impact, were you facing: ☐ Right ☐ Left ☐ Forward
Were you ☐ aware of or ☐ surprised by the impact?

Did any part of your body strike anything inside of the vehicle? ☐ Yes ☐ No If yes, please describe:_____________________________________________________________________________________

Did accident render you unconscious? ☐ Yes ☐ No If yes, for how long? ____________________

How did you feel immediately after the accident?_____________________________________________________

______________________________________________________________________________________________

Did you seek post-accident hospitalization?_________ If yes, at what hospital? ________________________

When did you go? ___________________________ How did you get there? ________________________

Describe any treatment you received_________________________________________________________

Were x-rays taken? ☐ Yes ☐ No Was medication prescribed? ☐ Yes ☐ No

Have you been seen by any other doctors since this accident? ☐ Yes ☐ No If yes, by whom?___________________

______________________________________________________________________________________________

What are your current complaints? ______________________________________________________________

______________________________________________________________________________________________

Is your condition getting: ☐ Better ☐ Same☐ Worse

**Indicate symptoms that are a result of this accident:**

| | | | | |
|---|---|---|---|---|
| ☐ Dizziness | ☐ Difficulty Sleeping | ☐ Jaw Problems | ☐ Back Pain | ☐ Arm/Shoulder Pain |
| ☐ Nausea | ☐ Memory Loss | ☐ Irritability | ☐ Headache(s) | ☐ Fatigue |
| ☐ Numb Hands/Fingers | ☐ Low Back Pain | ☐ Blurred Vision | ☐ Back Stiffness | ☐ Chest Pain |
| ☐ Tension | ☐ Buzzing in Ear | ☐ Neck Pain | ☐ Neck Stiffness | ☐ Leg Pain |
| ☐ Shortness of Breath | ☐ Upset Stomach | ☐ Numb Feet/Toes | ☐ Other ________________________________ | |

Have you retained an attorney? ☐ Yes ☐ No

Attorney's Name and Address: ___________________________________________________________________

His/Her Phone Number: ________________________

**To evaluate the effect that continuing work will have on your recovery, please complete the following:**

How many hours/day do you work?_______________ Have you been able to work since this injury? ☐ Yes ☐ No

If you lost any days of work, please list those dates: ___________________________________________

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

What are your job duties?__________________________________________________________________

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you can request? ☐ Yes ☐ No ☐ N/A

How was your health **prior** to the accident? (Please list all complaints)_______________________________________

______________________________________________________________________________________________

Have you had any **previous** accidents, auto or otherwise? ________

If yes, describe the accident and any resulting injuries: __________________________________________________

______________________________________________________________________________________________

**Primary Accident Coverage**

Insurance Co. Name:___________________________ Address:_______________________________________________

ID or Claim#:_____________________ GRP#:______________ Insured's Name:_________________________________

Relation:_________________ DOB:________________ Insured's Employer: _______________________________

**Secondary Accident Coverage**

Insurance Co. Name:___________________________ Address:_______________________________________________

ID#:_____________________ GRP#:_______________ Insured's Name:___________________________________

Relation:_________________ DOB:________________ Insured's Employer: _______________________________

**We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.**

- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature_________________________________________ Date _____/_____/_____

Guardian or Spouse's Signature_________________________________________ Date _____/_____/_____