CHIPROPRACTIC 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: ______________________________________

The reason for this visit is a result of: ☐ work ☐ sports ☐auto ☐ trauma ☐ chronic

Explain what happened:____

____

Please describe the pain and its location: ____

____

When did condition begin?_____/_____/_____ Have you had this or similar conditions in the past? ☐ Yes ☐ No

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is this condition interfering with your: ☐ work ☐ sleep ☐ daily routine If so, please explain:___________________

____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No If so, where?___________________

____

Name and address of primary physician ____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No If yes, please explain:______________________

____

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____

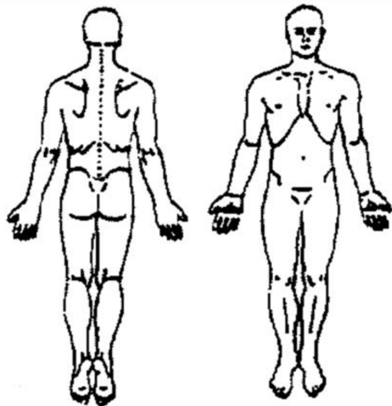
List any past serious accidents and dates____

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

Please mark the location of your pain on the following



Insurance Co. Name:___________________________

Address:______________________________________

____

ID#:_____________________ GRP#:_______________

Insured's Name:________________________________

Relation:_________________ DOB:________________

Insured's Employer: ____________________________

Please inform front desk of any 2nd insurance source

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 _____/_____/_____