New Patient Preliminary Information
Health History Questionnaire

Name _____ Birth Date _____
(First) (Middle) (Last)
Mr. Mrs. Miss Dr. Single Married Separated Divorced Widowed

Home Address _____ Email _____
(Street) (City) (State) (Zip Code)

Phone: Home _____ Cell _____ Social Security Number _____
(Please indicate which is the best way to reach you)

Patient Employed by _____ Occupation _____

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

Name of Spouse _____ Employed by _____
(If patient is a minor/student indicate Parent/Legal Guardian)

Referred By _____ Who is responsible for this account? _____
(How did you hear about us?)

What are your main problems? _____

_____

Date that symptoms began/Date of Accident _____ Hour _____ AM PM

Location of Accident _____ How did it occur? Auto Accident Work Other

Please describe the circumstances _____

Have you lost time from work? _____ Dates _____

Have you ever had the same conditions? _____ If yes, when? _____

What other health care have you received for this current condition? _____

Female: Are you pregnant? _____ Number and ages of children _____

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

Group Insurance _____ BlueCross BlueShield _____ Aetna _____ United Healthcare _____ Medicare _____
Auto Insurance _____ Personal Injury _____ Worker's Compensation _____ Other _____

Please present your insurance card to be photocopied. Thank you.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____
(If patient is a minor, the signature of their parent or guardian)

Patient Name: _____ Date: _____

Previous Accidents *(auto, work, sports, falls, etc.)*: _____

_____

Prior Surgeries: _____

_____

Medications presently taking: _____

_____

Vitamins, Supplements presently taking: _____

_____

Are you ALLERGIC to any medications? If so please list them: _____

I currently have: ☐Diabetes ☐High Blood Pressure ☐High Cholesterol ☐Asthma ☐Bronchitis ☐Allergies
☐Osteoporosis ☐Cancer ☐Pacemaker ☐Cold Feet/Hands ☐Leg Cramps ☐Constipation
☐Digestive Problems ☐Frequent Urination ☐Swelling of Ankles ☐Other _____

Family History *(parents, siblings, etc.)* of _____

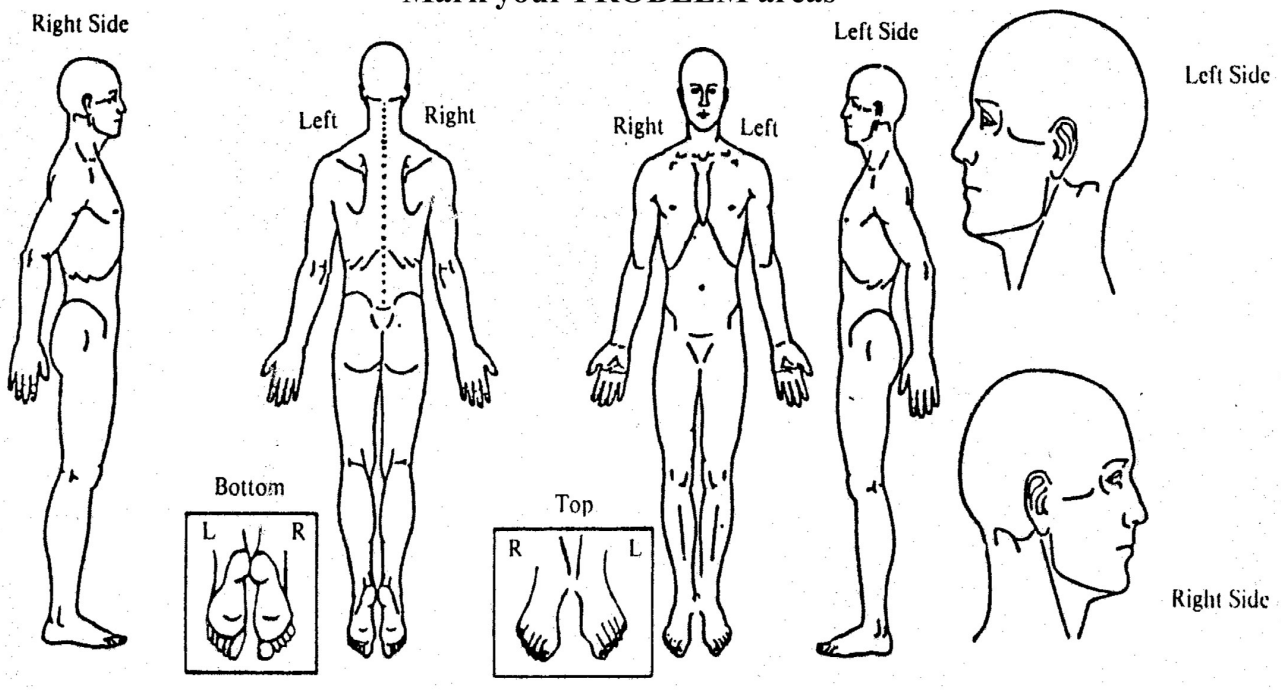
_____

Measure your PAIN today:

Mark your pain for ALL areas of pain

No Pain |---------|---------|---------|---------|---------| **Incredible Pain**

Mark your PROBLEM areas



Symptom Questionnaire

This information will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. The doctor will go over the questions with you when completed.

Patient Name: _____ Date: _____

Where are you having your major problems?
☐Head ☐Neck ☐Lower Back ☐Between Shoulder Blades
☐Shoulder ☐Elbow ☐Hip ☐Knee ☐Ankle ☐Jaw ☐Other _____

How long has this current condition lasted? _____

Is this current condition: ☐ Getting Worse ☐ The Same ☐ Improving ☐ Other: _____

Please describe the initial cause of your current condition_____

_____

_____

_____

Pain came on: ☐ Gradually ☐ Suddenly The Pain is: ☐ Occasional ☐ Frequent ☐Constant

Describe the pain: ☐ Sharp *(like a knife stabbing you)* ☐ Dull *(like a toothache)* ☐ Burning *(hot)*

Does the pain: ☐ Stay in one spot ☐ Radiate *(travel or shoot down your leg or arm)* ☐ Go up or down the spine

What time of day is the pain the worst? ☐Morning ☐Afternoon ☐Evening ☐Night *(when in bed)* ☐All the time

Do you have pain in: ☐Legs ☐Feet ☐Arms ☐Hands ☐Other _____ ☐Left ☐Right

Do you have numbness, tingling, or pins and needles in: ☐Legs ☐Feet ☐Arms ☐Hands ☐Other ☐Left ☐Right

What makes the pain worse? _____

What makes the pain better? _____

Do changes in the weather affect your pain/symptoms? _____

Does the pain affect your sleeping? ☐No ☐Occasionally ☐Frequently ☐Constantly _____

Does the pain affect your work? ☐No ☐Occasionally ☐Frequently ☐Constantly _____

Does the pain affect your daily life? ☐No ☐Occasionally ☐Frequently ☐Constantly _____

Smoking Status: ☐Never Smoked ☐Former smoker ☐Smokes every day ☐Smokes some days

Have you been hospitalized in the last 5 years? ☐No ☐Yes If yes, for what? _____

Have you had major surgery in the last 5 years? ☐No ☐Yes If yes, what surgery? _____

Have you seen other doctors for this current condition? ☐No ☐Yes If yes, doctor's name? _____

Have you ever seen a chiropractor before? ☐No ☐Yes If yes, doctor's name? _____