Paul Chiropractic and Health Center

Chiropractic Patient Questionnaire

Date_____________________ Patient#_______________

Name _____________________________ SS#______________________ Date of Birth__________________
Address____City/State__________________________Zip________
Home Phone_______________________ Cell Phone_____________________________
E-Mail Address____
Occupation___________________Employer______________________________Work #_________________
Married____Single____Widow(er)____Divorced____ Number of Children_____
Spouse______________________Employment____________________________Work#____________________

Whom may we thank for referring you to us? ____

Personal Habits
Are you currently using any:_____Medication_______Drugs_____Tobacco_____Alcohol_____Coffee
_____Vitamins/Minerals/Herbs_____Exercise

List all medications you are currently taking____
____

Present Health Statistics
Height__________Weight________Have you experienced any significant weight change in the past three months?____Yes____No. If yes, please describe change____

Please list your symptoms below in order of importance and give date symptoms began.

1.____Date__________________
2.____Date__________________
3.____Date__________________
4.____Date__________________

Is this condition due to an auto accident?____Yes____No. If yes, list date of accident____________.
Who was at fault?____
Is this condition a direct result from an injury which occurred at work?___Yes___No. If yes, date and time of injury______________________________________. Did you report this injury to your employer?__Yes__No.

Do you have health insurance?___Yes___No. If yes, name of company_______________________________
Please present your insurance card so that we can make a photocopy for our records.

In case of an emergency who should be contacted? Name____
Daytime phone#____________________________Relationship_____________________________

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. Payment expected at time of visit. **The patient understands and agrees to allow this chiropractic officd to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concening those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the desk before signing this consent.

Patient Signature:_______________________________ Date___________________
If under 18 years of age, parent or legal guardian signature:____

Health History

Have you ever had the same or similar symptoms? _____Yes_____No. I yes, when?________________________________
Have you had treatment by another doctor for these symptoms? _____Yes_____No.
If yes, name of doctor____
Is there any family history of this type of pain? _____Yes_____No.
Have you had any previous Chiropracitc care? _____Yes_____No.
Have you ever been hospitalized? ____Yes_____No. If yes, when and why?____
____
Have you ever broken any bones? _____Yes_____No. If yes, when and what?______________________________________
____
Have you noticed any recent changes in bowel or bladder habits? _____Yes_____No. If yes, please describe___________
____

Please check below if you or a member of your family, has ever been diagnosed with or suffered from:

You	Family	Relationship(Father, Mother, Sister …	
_______	_______	_______	1. Cancer
_______	_______	_______	2. Diabetes
_______	_______	_______	3. Thyroid Disease
_______	_______	_______	4. Hypertension (High Blood Pressure)
_______	_______	_______	5. Hypercholesterolemia (High Cholesterol)
_______	_______	_______	6. Atherosclerosis (Heart Disease)
_______	_______	_______	7. Kidney Disease
_______	_______	_______	8. Osteoporosis
_______	_______	_______	9. Nueromuscular Disease (i.e. Parkinson's, Multiple Sclerosis)
_______	_______	_______	10. Rheumatoid arthritis
_______	_______	_______	11. Allergies/Asthma
_______	_______	_______	12. Scoliosis
_______	_______	_______	13. Low back pain/or surgery
_______	_______	_______	14. Headache/Migraine
_______	_______	_______	15. Gastrointestinal Problem (Gallbladder, Ulcers, Diverticulitis)
_______	_______	_______	16. Liver Disease (Hepatitis, Cirrhosis)
_______	_______	_______	17. Other____

Please notify the Doctor if you suffer from any medical condition not listed on this form.

Female Health History
Date of last menstrual cycle______________________. Was it ________regular or________irregular?
Is there any possibility that you are pregnant? _____Yes_____No_____Maybe
Are you using some form of birth control? _____Yes_____No. If yes,____________________________________
Do you have an annual gynecological exam? _____Yes_____No.
If over 40, do you have a regular mammogram? _____Yes_____No.

Male Health History
Do you have a regular prostate exam? _____Yes_____No
Have you had a recent Prostate Specific Antigen test? _____Yes_____No

Primary Care Provider
Do yu have a primary care physician? _____Yes_____No. If yes, and your condition requires, we would like to keep your Doctor informed about your condition and the care you receive at our office. If you have no objection to this, sign and date here, giving us authorization to release your medical records.
Signature______________________________________ Date________________________
Witness____ Date_________________________

Doctor's name__________________________________ office address____
____ and phone #____________________________________.