

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask the front desk, and we will be happy to help you.

First Name:_____ Middle Initial:____ Last Name_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone #: ()_____ Cell Phone #: ()_____

Age:_____ Date of Birth:_____ SS#:_____

Marital Status: __M __S __D __W

Your Occupation:_____ Employed By:_____

Address:_____ Phone #:_____

Your Spouse's Name:_____

Spouse's Employer:_____ Spouse's Work Phone #:_____

Name of person to contact in case of emergency:_____

Their home phone #:_____ Work phone #:_____

Is your visit due to an accident? Yes/ No Are you a Medicare Patient? Yes/ No

Who referred you to this office so we may thank them?_____

Name of Primary Care Physician:_____

THERE WILL BE NO SERVICES CHARGED WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: _____ Date:_____

Parent or Guardian (if patient is a minor):_____

Signature: _____ Date: _____

Insurance Coverage Information

Medical Insurance Carrier:_____

Please make sure the front desk gets a copy of your card.

Is this a Workers Compensation Injury? Yes / No

Is this an Auto/Personal Injury? Yes/ No

If yes to either question, please inform the front desk.

Present Complaints (please circle all that apply)

- | | | |
|-------------------|--------------------------|-----------------------|
| Headache | Feet/hands cold | Head seems heavy |
| Mental dullness | Depression | Confusion |
| Loss of memory | Pins and needles in arms | Constipation |
| Dizzy | Rib pain | Unbalanced |
| Neck Pain | Neck stiffness | Chest pain |
| Fainting | Shortness of breath | Ears ringing/buzzing |
| Upper back pain | Upper back stiffness | Midback pain |
| Lower back pain | Lower back stiffness | Blurred/Double vision |
| Neck restriction | Eye strain/pain | Loss of taste |
| Nervousness | Fear | Irritability |
| Midback stiffness | Tension | Loss of Smell |

Difficulty in:___Standing ___Sitting ___Bending ___Walking ___None

Pain radiation to the:___Right arm___Left arm___Right leg___Left leg___None

Cannot lift:___Light___Moderate___Heavy___Repetitive___No problem lifting

Pain radiating to:___Neck___Base of skull___Ribs___Shoulders___Arms ___Hands

Pain in the: ___foot___ankle___knee___hip___heel spurs

Other:_____

On what date did you symptoms first begin?_____

Have any of the above complaints interrupted your sleep? Yes/ No

How:_____

Does anyone in your family have the same or similar condition(s)? Yes/ No

If yes, who:_____

List any doctors or therapists that you have seen for this complaint:

1. _____Specialty:_____

2. _____Specialty:_____

3. _____Specialty:_____

Relevant Medical History (Please circle the conditions you have or had previously)

- | | | |
|--------------------|---------------------|---------------------|
| Arthritis | Epilepsy | Muscular Dystrophy |
| Asthma | Fibromyalgia | Neck pain or spasms |
| Anemia | Hand or wrist pain | Neuritis |
| Back pain or spasm | Headaches | Numbness |
| Cancer | Heart problems | Polio |
| Concussion | Hepatitis | Rheumatic Fever |
| Convulsion | High blood pressure | Sinus trouble |
| Diabetes | HIV | Sciatica |
| Digestion problems | Measles | TB |
| Dizziness | Multiple sclerosis | Venereal disease |

List any operations that you have had and approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Are you allergic to any medication?

Please list: _____

Are you taking any medications?

Please list: _____

Do you wear Orthotics (shoe inserts)? Yes / No

If yes, what type? _____

Are you pregnant? Yes / No Due Date: _____

Do you: Smoke: Yes / No Amount per day: _____

 Drink: Yes / No ___Light ___Medium ___Heavy

 Exercise: ___Never ___Sometimes ___Frequently ___Regularly