NEW PATIENT HEALTH QUESTIONNAIRE

Date: _____ Referred by: _____

Full Name: _____ S.S.#: _____

Age: _____ Date of Birth: _____ Gender: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Contact in case of emergency: _____ Phone: _____

Do you have medical insurance? □ Yes □ No Name of Health Insurance _____

ID #_____ Do you have a Health Savings Account (HSA)? Yes No

Please give copies of Insurance cards and a picture ID to the Front Desk Secretary

Is this your first visit to a chiropractor? □ Yes □ No If no, when was your last visit? _____

Are you pregnant? □ Yes □ No Due Date: _____

Please list any surgeries: _____

Have you had an □ X-ray □ MRI ? □ Yes □ No

If yes, please list the facility name & phone number: _____

Do you have a Primary Care Physician? □ Yes □ No

Name, Address & phone number: _____

How did you hear about our office? _____

Briefly explain the reason for today's visit: _____

_____

When did your symptoms appear _____

On a pain scale of 1 – 10, 1 being almost no pain and 10 being the greatest, what do you rate your pain today? ____

Please mark off your symptoms:

□ Headaches	□ Shoulder pain – Lt / Rt	□ Low back pain	□ Ankle pain
□ Neck pain	□ Arm pain – Lt / Rt	□ Sciatica	□ Carpal Tunnel
□ Vertigo (Dizziness)	□ Mid-back pain	□ Hip pain Lt/Rt	□ Allergies
□ TMJ (Jaw pain)	□ Rib pain	□ Leg pain – Lt / Rt	□ Rheumatoid Arthritis
□ Chronic Sinusitis	□ Chest pain	□ Knee pain – Lt / Rt	□ Osteoarthritis

□ Numbness / tingling in hands □ Numbness / tingling in feet □ Other: _____

EXERCISE:	**WORK ACTIVITY**	**HABITS**	
□ None	□ Sitting	□ Smoking	Pack/Day _____
□ Moderate	□ Standing	□ Alcohol	Drinks/Week _____
□ Daily	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day _____
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason _____

HEALTH HISTORY:

Is your current condition the result of a Motor Vehicle Accident or Injury? Please circle YES or NO

If yes, please provide Date of Accident_____

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐other: _____

Name and address of other doctor(s) who have treated you for your condition _____

_____

Please check off your medical history:

☐ AIDS/HIV	☐ Anemia	☐ Appendicitis	☐ Arthritis	☐ Asthma
☐ Bleeding Disorders	☐ Breast Lump	☐ Bronchitis	☐ Cancer	☐ Cataracts
☐ Chemical Dependency	☐ Diabetes	☐ Emphysema	☐ Seizures/Epilepsy	☐ Fractures
☐ Glaucoma	☐ Goiter	☐ Gout	☐ Heart Disease	☐ Hepatitis
☐ Hernia	☐ Herniated Disk	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease
☐ Migraine Headaches	☐ Miscarriage	☐ Mononucleosis	☐ Multiple Sclerosis	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatoid Arthritis	☐ Thyroid Problems	☐ Tonsillitis	☐ Tuberculosis	☐ Tumors, Growths

MEDICATION:	**ALLERGIES:**	**VITAMINS/HERBS/MINERALS:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient