CONFIDENTIAL HEALTH QUESTIONNAIRE

Please Print in Ink

Name:_____
First Middle Last

Address:_____
Street City State Zip

Age_____ Birthdate(M/D/Y)_____ Marital Status- S M W D SEP

Number of Children_____ Spouse's Name_____

Your Employer_____ Occupation_____

Business Address_____ Work Phone_____

Social Security Number_____ Home Phone_____

Referred By_____

Insurance Company Name_____ Policy or Claim No._____

Address_____ Phone_____

Insured's Name (if different from patient) _____

Insured's SS Number (if different from patient)_____ Medicare: Yes No

On the Job Injury Date_____ Car Accident Date_____

Payment for services is due when rendered. As a service to our patients we accept reimbursement from most insurance companies for covered services. Some fees may not be reimbursable by insurance. These non-covered fees are payable in full at the time of each visit. Our fees are not determined by insurance companies. The patient is always responsible for the entire bill regardless of insurance company limitations. Please present insurance information to the receptionist.

Signed_____ **Date**_____

CONSENT TO TREAT MINOR CHILD- I Authorize and give consent for the doctor to administer chiropractic health care as deemed necessary to my son/daughter.

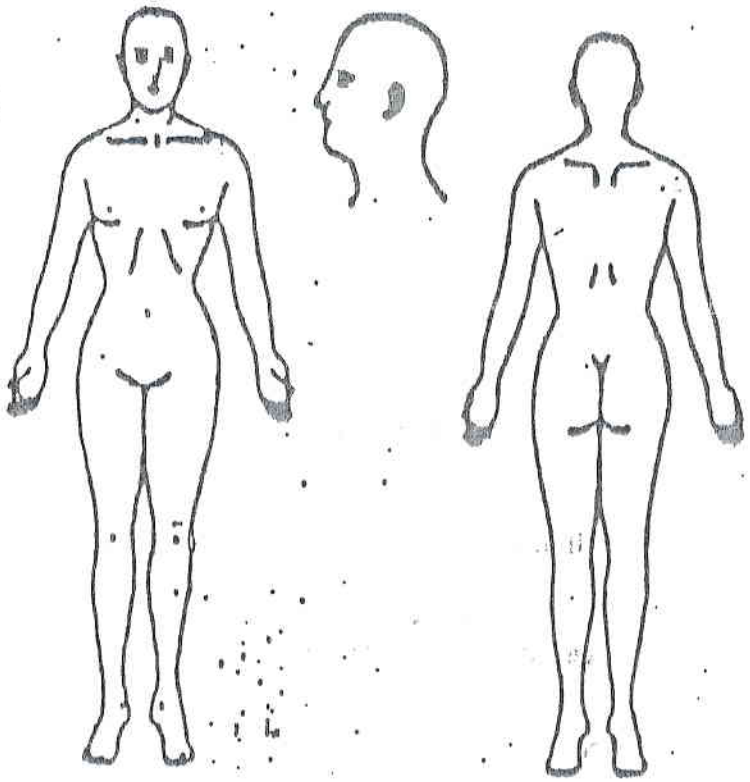
Name_____ Date_____ Signed_____
Minor Parent or Guardian

1. 2/12/96

Have you been ever seen by a chiropractor before?_____ If so, who, when and why_____

Please list your major problems in order of their importance_____

Please mark your areas of pain on the figures below.



Describe the location and nature of your trouble ___

When was the most recent occurrence of this difficulty

How did it occur_____

If X-rayed in the last 12 months Where, when and why and what views_____

Medications, vitamins and minerals you are now taking_____

What previous methods and what other health practitioners have you consulted for this problem?

Please check any symptoms you currently or have had in the past.

☐ Neck pain	☐ Back pain	☐ Headaches	☐ Shoulder Pain
☐ Arm pain	☐ Hand pain	☐ Leg pain	☐ Foot pain
☐ Hip pain	☐ Knee pain	☐ Elbow Pain	☐ Weakness
☐ Digestive problems	☐ Gas	☐ Bloating	☐ Burping
☐ Constipation	☐ Diarrhea	☐ Asthma/allergies	☐ Fatigue
☐ Hypoglycemia	☐ Mood swings	☐ Blurry vision	☐ Stroke
☐ Diabetes	☐ Heart/lung disease	☐ Arthritis	☐ Cancer

Weight _____ Gained or lost in the past 5 years_____

Family History: Mother: Living or Deceased

Father: Living or Deceased

Check the following: Mother, Father, Sister, Brother have:

Diabetes	Cancer	TB	Heart Disease
High BP	Low BP	Hypoglycemia	Other

2. 2/12/96

Effect on Symptoms	No Effect	Better	Worse
Movement			
Sitting			
Standing			
Walking			
Lying down			
During the night			
Sleeping			
First thing in the AM			
Toward end of day			
During great activity			
While resting			
Before meals			
During meals			
After meals			
2-4 hours after meals			

List your major car accidents, falls injuries, broken bones and other related accidents. Give Dates _____

List any diseases you currently have or have had. _____

List any type of surgery or major dental work. Give dates _____

_____

Right or left handed? How much do you smoke? _____

Do you have any sexually related problems? _____

Number of times you urinate during day_____ Night_____

How often do you have a bowel movement? _____

Are you under emotional stress? _____ Do you have sufficient energy for your normal activities?

Drink alcohol? _____ How much?_____ Do you drink coffee (incl. decaf), teas, soda, cola? Please give cups per day_____ Do you eat any of the following and how much per week? Hot spicy food, chocolate, popcorn, dairy products _____ How much water do you drink in a day____ Are you wearing heel, sole lift, orthotics or arch supports? _____

FOR WOMEN ONLY

Date of last menstrual period_____ How many days do you menstruate?_____ Days between first day of period_____ List any menstrual discomfort_____

X-RAY CONFIRMATION THIS IS TO CONFIRM THAT I HAVE BEEN ADVISED BY THE DOCTOR THAT X-RAYS CAN BE HAZARDOUS TO AN UNBORN CHILD. I AM NOT PREGNANT OR TRYING TO BECOME PREGNANT AND CONSENT TO X-RAYS.

Date_____ Signed_____

3 2/12/96