Patient Questionnaire

Last Name: _____ First: _____ Middle: _____

Spouse Name: _____ Children's names & ages: _____

Sex: _____ Date of Birth: _____ Social Security #: _____

Drivers Lic. #: _____ Home Ph. #: _____

Work Ph. #: _____ Cell Ph. #: _____ Carrier_____

E-mail address: _____

Patient Mailing Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Employed by: _____

Emergency Contact Name: _____ Ph. #: _____

Address: _____

How did you hear about our office? _____

Who is Financially Responsible For This Bill? _____ Ph. #: _____

I Will Be Paying Cash _____ Check _____ Credit Card _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional service rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in health status or the above information.

_____ _____

Signature Date

Insurance Information

Insured's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: _____

Is insured employed and covered by employer's health plan? _____ (Y / N) _____

Primary Insurance Name: _____

Policy or ID #: _____ Group #: _____

Secondary Insurance Name: _____

Policy or ID #: _____ Group #: _____

Other Insurance Name: _____

Policy or ID #: _____ Group #: _____

Is patient here as a result of an accident? _____ (Y / N) Work Injury? _____ (Y / N)

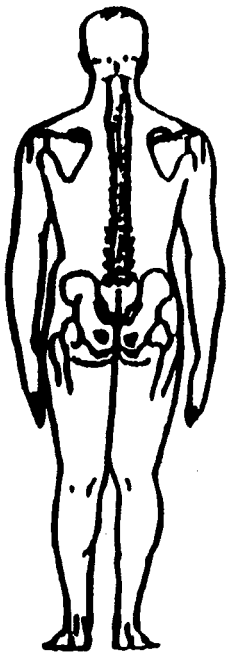
Accident Date: _____ Job related (Y / N) _____ Workman's Comp. (Y / N) _____

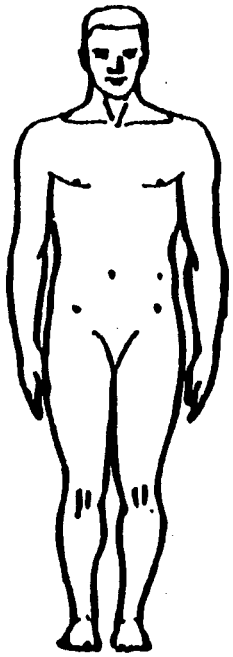
Accident Type: ____ (A) uto ____ (W) ork ____ (H) ome ____ (R) ecreation ____ (S) ports ____ (O) ther ____ (N) one

PATIENT INFORMATION PAGE 2

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, on & off, when standing, when sitting, etc.

COMPLETE THESE DIAGRAMS





MAJOR COMPLAINT

(Please describe only your major problems)

How did this condition develop? (What caused it? How did it start?) _____

When was the first time you were aware of this problem? _____

Have you ever had this problem before? If yes, please explain: _____

Have you ever received any treatment for this condition? If yes, where and when, and what were the results?

Has this problem been getting better, worse, or staying the same? _____

PATIENT HISTORY

FAMILY HISTORY

Patient _____ Date _____
Nearest Relative _____
Parents: Father (age) _____ Mother (age) _____ Children: (B)_____ (G)_____
Family Disease: TB_____ Cancer _____ Mental Disease _____ Diabetes _____ Asthma_____
Heart Disease _____ Kidney Disease _____ Lung Disease _____ Arthritis _____ Liver _____

PERSONAL HISTORY

Childhood Diseases: Measles _____ Mumps _____ Chicken Pox _____ Others _____
Usual Childhood Diseases: _____
Adult Illnesses or Conditions: _____
Surgeries: _____
Fractures: _____
Medications: _____ Smoke _____ Drink _____ Supplements_____
Allergies _____ Symptoms to Allergies _____
Last Physical (date) _____ Findings: _____
Last D.C. Exam (date) _____ Findings: _____

Chief Symptoms

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Recent Falls / Injuries: _____
_____
_____

Hobbies: _____ Symptoms Occurred: _____
Same or Similar: _____ Illness or Injury _____
Disability: _____ From _____ To _____ Hospitalized: _____

SYMPTOMS PREVIEW

____ Headaches
____ Blurred Vision
____ Dizziness
____ Low Energy
____ Labored Breathing
____ Pain With C/S/BM
____ Indigestion/Heartburn
____ Throat Lump/Constriction
____ Numbness
____ Fainting/Light Headed
____ Swelling
____ Ears/Nose/Sinus/Voice/Mouth
____ Insomnia
____ Pain At Night

____ Excessive Gas
____ Constipation
____ Loose Stool
____ Urinary Track
____ Hot Flashes
____ Poor Memory
____ Sexual Impotency
____ Excessive Sweating
____ Heart Palpitation
____ Dry/Oily Skin
____ Poor Appetite
____ Emotional
____ Other: _____
____ Other: _____

_____
_____
_____
_____

FEMALE HISTORY

____ Possible Pregnancy
____ Date of Last Period
____ Birth Control Method
____ Intermenstrual Spotting
____ Discharge Color _____
____ Menses Flow Length of Time
____ Other: _____
_____
_____
_____
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_____
_____

Patient Name: _____ **Date:** _____

Medication/Allergy List

Name of Medication	Dosage	Purpose for Medication

Medication Allergy	Symptoms

PERSONAL INJURY/WORKERS' COMPENSATION QUESTIONNAIRE

NAME:_____ Date of Accident: _____ Time: _____

Where did accident happen?_____
Describe the accident in your own words: _____
_____
_____

What was your position in the car? ☐ Driver ☐ Passenger
If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear
Did your vehicle strike other vehicle? ☐ Yes ☐ No Was your car struck by other vehicle? ☐ Yes ☐ No
Was the impact from: ☐ the front? ☐ from the right side? ☐ from the left side? ☐ from the rear?

At the time of the impact were you: ☐ looking straight ahead? ☐ looking right? ☐ looking left?
Were both hands on steering wheel? ☐ Yes ☐ No Was your foot on brake? ☐ Yes ☐ No
Were you braced for impact? ☐ Yes ☐ No

Where in the car were you after the accident?_____
Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No
If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rest ☐ Side Window
Please state part of body: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head

Immediately following the accident how did you feel?_____
_____

Were you unconscious? ☐ Yes ☐ No in a daze? ☐ Yes ☐ No Did you go to the hospital? ☐ Yes ☐ No

If you went to hospital, when? At the time of accident ☐ Yes ☐ No Next day ☐ Yes ☐ No
How did you get to the hospital? Ambulance ☐ Yes ☐ No Private Transportation ☐ Yes ☐ No

Did the ambulance attendants place you in: Neck Collar ☐ Yes ☐ No Splints ☐ Yes ☐ No Brace ☐ Yes ☐ No

Name of Hospital_____

Attended by Dr. _____ Were you x-rayed at hospital ☐ Yes ☐ No

If so, what was the diagnosis? _____

Were you admitted to the hospital? ☐ Yes ☐ How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? ☐ Yes ☐ No See orthopedic doctor? ☐ Yes ☐ No
Physical Therapy ☐ Yes ☐ No
Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No
Doctor's name_____

Have you lost any time from work because of this accident? ☐ Yes ☐ No
If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____

Partially disabled from _____ to _____