NEW PATIENT QUESTIONNAIRE

DATE _____/_____/_____

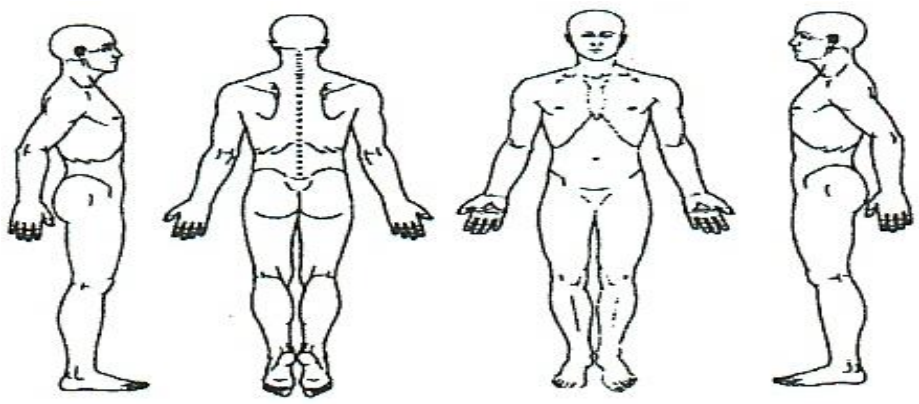
NAME _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE_____ZIP_____
DATE OF BIRTH _____/_____/_____ SOC. SEC. #_____-_____-_____ MARITAL STATUS_____
EMPLOYER_____HRS PER WEEK_____WORK PHONE _____
TYPE OF WORK DONE_____
ADDRESS_____CITY_____STATE_____ZIP_____
E MAIL ADDRESS_____CELL PHONE #_____
HOW DID YOU HEAR ABOUT OUR CLINIC?_____

SYMPTOM/ PAIN INFORMATION:

1. PLEASE DESCRIBE THE HEALTH PROBLEM FOR WHICH YOU CAME TO OUR OFFICE._____
   _____
2. DESCRIBE YOUR SYMPTOMS. SOME WORDS OFTEN USED INCLUDE BURNING, TINGLING, ACHING, TIRED, NUMB, SHARP, DULL, STABBING, SHOOTING, RADIATING, ETC._____
3. PLEASE DESCRIBE IN DETAIL WHAT CAUSED YOUR SYMPTOMS._____
   _____
4. SHADE IN THE AREAS ON THE DIAGRAM WHERE YOU FEEL SYMPTOMS. MARK THE AREAS ON THIS DIAGRAM WHERE YOU FELT THE DESCRIBED SENSATIONS. USE THE SYMBOLS IN ALL AFFECTED AREAS.

NUMBNESS: xxxxxxxxxxxxx PAIN: CIRCLE OOOOOOO RADIATING: ARROW ->->->->



5. PLEASE DESCRIBE HOW INTENSE THE PAIN HAS BEEN. A ZERO IS NO DISCOMFORT, A TEN IS THE WORST POSSIBLE PAIN.

NOW: NO PAIN 0--------1---------2--------3--------4----------5---------6---------7---------8--------9-------10 WORST POSSIBLE PAIN

AVERAGE: NO PAIN 0--------1---------2--------3---------4----------5---------6---------7---------8--------9-------10 WORST POSSIBLE PAIN

WORST: NO PAIN 0--------1---------2--------3--------4----------5---------6---------7---------8--------9--------10 WORST POSSIBLE PAIN

6. WHEN DID THE SYMPTOMS START:_____
7. SINCE THIS TIME THE SYPTOMS HAVE: INCREASED/ DECREASED/ REMAINED THE SAME
8. HAVE YOU HAD THESE SYMPTOMS IN THE PAST:_____
9. IF YES, WHEN WAS THE FIRST TIME YOU NOTICED THESE SYMPTOMS_____

10. HOW OFTEN DO YOU HAVE THESE SYMPTOMS: (CONSTANT) (0-25%) (26-50%) (51-75%) (76-100%) (DAILY) (AM) (PM) (WHILE SLEEPING) _____PER_____EX. 1 PER WEEK

11. WHERE DID THE SYMPTOMS BEGIN? HOME_____AUTO_____WORK_____OTHER_____
12. IS THERE ANY TIME OR CONDITION WHEN THE SYMPTOMS DECREASE, PLEASE EXPLAIN_____
_____
13. IS THERE ANY TIME OR CONDITION WHEN THE SYMPTOMS INCREASE, PLEASE EXPLAIN_____
_____
14. HAVE YOUR ACTIVITIES OF DAILY LIVING (WORK, HOME, OR RECREATIONAL ACTIVITIES) OR SLEEP BEEN AFFECTED BY YOUR SYMPTOMS?_____
15. HAVE YOU TRIED ANYTHING TO RELIEVE YOUR SYMPTOMS, SUCH AS OTHER HEALTH PROFESSIONALS, REST, ice/heat, MEDICATIONS, ETC._____
16. HAVE ANY FAMILY MEMBERS HAD SIMILAR SYMPTOMS? _____

SOCIAL HISTORY

1. DEGREE OF REGULAR EXERCISE YOU PERFORM. 1 NONE 2 LIGHT 3 MODERATE 4 STRENUOUS
2. HOW WOULD YOU DESCRIBE YOUR DIET? 1 POOR 2 AVERAGE 3 GOOD 4 EXCELLENT
3. DO YOU SMOKE OR USE TOBACCO PRODUCTS?_____IF YES, HOW OFTEN?_____
4. HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES, TRAUMAS, SURGERIES OR BEEN HOSPITALIZED?_____

IF YES, DESCRIBE_____

6. PLEASE LIST ALL MEDICATIONS INCLUDING BIRTH CONTROL PILLS, ASPIRIN, CORTIZONE OR VITAMINS THAT YOU ARE TAKING. _____
_____

7. PLEASE LIST ANY SERIOUS ILLNESS (CANCER, ARTHRITIS, HEART PROBLEMS, DIABETES, LUPUS, ETC.) THAT ANY IMMEDIATE FAMILY MEMBER MAY HAVE EVER HAD._____
_____

MEDICAL HISTORY:

PLEASE INDICATE AREA WHERE YOU HAVE HAD PAIN OR MEDICAL PROBLEMS IN THE PAST OR PRESENT.

	PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
HEADACHES	O	O	HIGH BLOOD PRESSURE	O	O	BRUISE EASILY	O	O
JAW PAIN	O	O	HEART ATTACK	O	O	DENTAL PROBLEMS	O	O
NECK PAIN	O	O	CHEST PAINS	O	O	DEPRESSION	O	O
UPPER BACK	O	O	STROKE	O	O	SLEEP PROBLEMS	O	O
LOW BACK	O	O	ANGINA	O	O	WEIGHT CHANGE	O	O
						ECZEMA/ RASH	O	O
SHOULDER	O	O	KIDNEY STONES	O	O	EXCESSIVE THIRST	O	O
ELBOW	O	O	KIDNEY DISORDERS	O	O	PAINFUL URINATION	O	O
WRIST	O	O	BLADDER INFECTIONS	O	O			
HAND	O	O	BLADDER DISORDERS	O	O	CANCER	O	O
			PROSTATE PROBLEMS	O	O	TUMORS	O	O
HIP	O	O				DIABETES	O	O
UPPER LEG	O	O	ABDOMINAL PAIN	O	O	EPILEPSY	O	O
LOWER LEG	O	O	ULCER	O	O	SYSTEMIC LUPUS	O	O
KNEE	O	O	HEPATITIS	O	O	ALLERGIES	O	O
ANKLE	O	O	LIVER DISORDERS	O	O	ASTHMA	O	O
FOOT	O	O	GALL BLADDER	O	O	HIV / AIDS	O	O
						FEMALES ONLY		
JOINT PAIN	O	O	VISION PROBLEMS	O	O	BIRTH CONTROL PILLS	O	O
FATIGUE	O	O	LOSS OF HEARING	O	O	PREGNANCY	O	O
TROUBLE MOVING	O	O	EARACHES	O	O	MENSTRUAL PAIN	O	O
PINCHED NERVE	O	O	SINUS PROBLEMS	O	O	OTHER HEALTH ISSUES		
MUSCLE CRAMPS	O	O	EAR PROBLEMS	O	O	_____		
MUSCLE SPASMS	O	O	EYE PROBLEMS	O	O	_____		
NUMBNESS	O	O	SWALLOWING	O	O	_____		

Please name your primary physician and their location._____
_____

Is it OK to contact them regarding this condition?____ yes no____

Have you used Chiropractic in the past?_____yes no__ How long ago?_____
Who?_____

Patient Financial Information

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

1. **YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL.**

2. As a courtesy to our patients we **will verify and bill your insurance** for you. Verification is not a guarantee of services and all questions should be directed toward the patient's insurance company.
3. Patients are responsible for all initial costs until insurance benefits are verified. If there is any overpayment, we will promptly refund it to you.
4. It is the policy of this office to collect a **co-pay at each** visit unless you prefer to pay weekly.
5. Any unpaid bills of over 3 months may be turned over to a credit bureau for further legal action.
6. Time of service patients must keep no balance and pay in full each visit. Otherwise discounts will be eliminated.
7. Missed appointments without 24-hour notice may be charged a missed appointment fee.
8. As a courtesy to our patients both time of service payment and insurance options will be discussed once insurance verification is completed.

Thank you for understanding our financial policy. Please let us know if you have any question or concerns.

I have read the financial policy. I understand and agree to this financial policy. All information given in the New Patient Questionnaire has been accurately answered.

The patient understands and agrees to allow this chiropractic office 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 concerning 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 front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENTS SIGNATURE:_____DATE_____

I authorize that this office including the doctor and staff that are deemed assistants to treat the minor child following the treatment plan that has been designed by this doctor.
PARENT OR GUARDIAN IF
MINOR:_____SIGNATURE_____

CHIROPRACTIC SPECIALISTS REPRESENTATIVE:_____

NOTES_____
_____