

Health Questionnaire

Patient Name	Date
Address	City/State/Zip
Home Telephone	Date of Birth Age
Social Security #	
Mothers Name	Cellular/Work Telephone
Fathers Name	Cellular/Work Telephone

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office?

Friend/Family member name _____

- Yellow Pages
 Telephone Call
 Sign
 Website
 Presentation
 Other _____

Please list any of the patient's health symptoms or health complaints.

1. _____ 2. _____ 3. _____

Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medication(s) is the patient currently taking? _____

Has the patient ever been diagnosed with cancer? Yes No Type _____ Year _____

Birth History: Many of the health challenges that people face later in life have their origins in stress from developmental years, some even starting at birth. Please answer the following questions regarding the patient's birth to the best of your ability.

Please check those that apply:

- | | |
|---------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Mother smoked/drank/drugs during pregnancy | <input type="checkbox"/> Epidural/Medication during labor |
| <input type="checkbox"/> Forceps Delivery | <input type="checkbox"/> Vacuum Extractor used |
| <input type="checkbox"/> C-Section Delivery | <input type="checkbox"/> Premature/Overdue |
| <input type="checkbox"/> Very Short Labor | <input type="checkbox"/> Breech Vaginal Delivery |
| <input type="checkbox"/> Very Long Labor | <input type="checkbox"/> Labor Induced |
| <input type="checkbox"/> Other | |

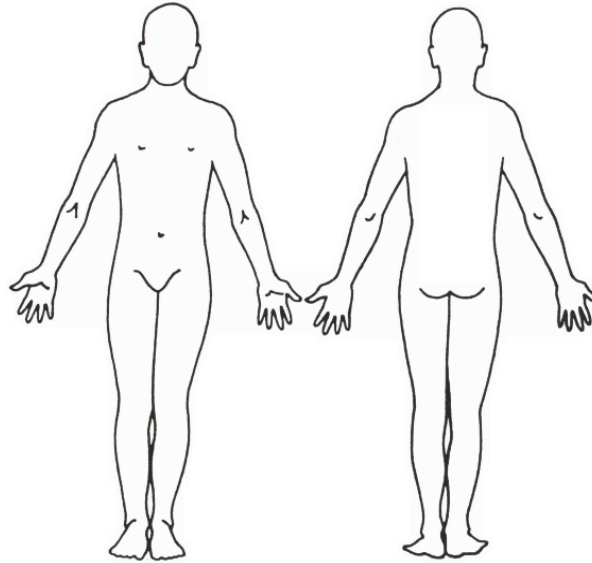
Please check any of the following that apply and if applicable, please list how many occurrences per day, week month or year.

- | | # of occurrences | | # of occurrences | | # of occurrences |
|-------------------------------------------|------------------|--------------------------------------|------------------|----------------------------------------|------------------|
| <input type="checkbox"/> Ear Infections | _____ | <input type="checkbox"/> Bed Wetting | _____ | <input type="checkbox"/> Vaccinated | _____ |
| <input type="checkbox"/> Asthma Attacks | _____ | <input type="checkbox"/> Croup/Cough | _____ | <input type="checkbox"/> Scoliosis | _____ |
| <input type="checkbox"/> Growing Pains | _____ | <input type="checkbox"/> Poor Sleep | _____ | <input type="checkbox"/> Severe Stress | _____ |
| <input type="checkbox"/> Digestive Issues | _____ | <input type="checkbox"/> Headaches | _____ | <input type="checkbox"/> Hard Falls | _____ |
| <input type="checkbox"/> Car Accident | _____ | <input type="checkbox"/> Seizures | _____ | <input type="checkbox"/> Surgery | _____ |
| <input type="checkbox"/> Chronic Colds | _____ | <input type="checkbox"/> Allergies | _____ | <input type="checkbox"/> Stitches | _____ |
| <input type="checkbox"/> Recurring Fevers | _____ | <input type="checkbox"/> Colic | _____ | <input type="checkbox"/> Broken Bones | _____ |
| <input type="checkbox"/> Poor Diet | _____ | <input type="checkbox"/> Other | _____ | | |

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Mark the areas on the body where the patient feels the described sensations using the appropriate symbols (if applicable).

<u>Numbness</u>	<u>Pins & Needles</u>	<u>Burning</u>	<u>Aching</u>	<u>Stabbing</u>
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////



Right Left Left Right

Please list any sports/activities that the patient is currently or has been involved in.

Has the patient ever been under chiropractic care? Yes No

When was the patients last adjustment _____ Chiropractors Name _____

Insurance Information:

Please be sure we have a copy of the patient's insurance card.

Does the patient have insurance? Yes No Type _____

Insured's Name _____ Insured's Social Security # _____

Relationship to Patient _____ Insured's Date of Birth _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians. The above information is true and accurate to the best of my knowledge. Chiropractic has only one goal and that is to reduce and eliminate subluxation.

Patient/Guardian Signature: _____ Date: _____