New Patient Questionnaire

Patient I.D. _____

Please Print

Name_____ Date_____
Address_____City_____ State_____ Zip_____
❑Male ❑Female ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated
Children? ❑ Yes ❑ No How Many & Ages _____
Birthdate_____ Home Phone_____ Cell_____
Work Phone_____ E-mail Address_____
Employer_____ Occupation_____ #years_____
Business Address_____City_____ State_____ Zip_____
Spouse or Parent's Name_____ Birthdate_____ Phone _____
Emergency Contact_____ Phone _____ Relation_____
Whom may we thank for referring you to us? _____
Did you see our Website?_____ Yellow Page Ad? _____ Other?_____
Name of local primary Physician_____ May we contact them?____

Insurance Information – If Insured, Please provide copy of insurance card

SYMPTOMS

Main Complaint_____ How Bad?_____ How Often?_____
When did it start?_____Getting Worse?_____Getting Better?_____
What activity bothers it the most? _____
When is it at its best?_____ When is it at its worst?_____
Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10
Other Chiropractors?_____ Positive Experience?_____
Other type of physician or therapist?_____ Positive Experience?_____
Additional Complaints_____

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers		Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other_____			

Women - How many children?_____Pregnant?_____Date of last Menstrual Cycle_____
Nursing?_____Taking Birth Control Pills?_____
Previous Surgeries and Dates? _____
_____
List ALL Medications you are currently taking _____
_____
What kind of exercise do you do? _____
What supplements do you take?_____
How much do you smoke per day?_____

***All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.**

Patient Signature_____ Date_____