Chiropractic New Patient Questionnaire

Patient Information

Name_____ Date_____ SS#_____
Address_____City_____ State_____ Zip_____
❑Male ❑Female ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated
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 Advertisement? ____ Internet Search? _____ Web Page? ____Other?_____
Name of local primary Physician_____ May we send them updates?_____
***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) 0 1 2 3 4 5 6 7 8 9 10
Other Chiropractors?_____ Positive Experience?_____
Other type of physician or therapist?_____ Positive Experience?_____
Secondary Complaint_____

Personal Health History - Please circle all that apply

Hypertension	Sinus/Ears	GI Disease	Major Trauma	Surgery
Neurological Disease	Arthritis	Pregnancy	Cancer	Endocrine
Medications	Skin Disease	Spinal Surgery	Scoliosis	Osteoporosis
Pacemaker/Defibrillator	Cardiovasular	Current Fever	Weight Loss	Insulin Pump
Respiratory Disease	Fatigue	Weight Gain	Blood Disorder	Stroke
Mental Health Issues	Allergies	Reproductive/Urinary	Headaches	Diabetes
Sports Injuries	Muscle/Joint Issues	Liver Disease	Fibromyalgia	AIDS/HIV/MRSA

Other_____
Women - How many children?____Pregnant?____Date of last menstrual cycle_____Nursing?_____
Previous Surgeries and Dates? _____
_____
List ALL Medications you are currently taking _____
_____
Exercise? _____Vitamins?_____
How much do you smoke per day?_____ Drinks per week? _____

*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_____