Active Family Chiropractic

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Patient Information and Health Questionnaire

(Please Print)

Patient Name____***Date***_____________________________

Date of Birth______________________________ ***Age***__________ ***Social Security Number***___________________________________

Address____ ***City***_____________________ ***State***______ ***ZIP***______________

Home Phone____ ***Work Phone***____

Cell Phone____ ***E-Mail***____

Sex: □ ***Female*** □ ***Male*** ***Marital Status:*** □ ***Single*** □ ***Married*** □ ***Divorced*** □ ***Widowed***

Occupation____ ***Employer***____

Work Address____ ***City***_____________________ ***State***______ ***ZIP***______________

Spouse's Name_____________________________________ ***Spouse's Employer*** _______________________________________

Emergency Contact__________________________________ ***Relationship***__________________ ***Phone***_______________________

How did you hear about our office? ____

Family Medical Doctor____

May we have your permission to update your medical doctor regarding your care at this office? □Yes □No

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident
□ Medical Savings Account & Flex Plans □ Other____________________________________

Primary Insurance Company____

Secondary Insurance Company (if any) ____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

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.

The following person(s) have my permission to receive my personal health information:

____

____

Patient Signature____***Date***______________________

Patient Name____***Date***______________________

1. Describe your symptoms ____

____

a. When did your symptoms start? ____

b. How did your symptoms begin? ____

2. How often do you experience your symptoms?
- □ Constantly (76-100% of the day)
- □ Frequently (51-75% of the day)
- □ Occasionally (26-50% of the day)
- □ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms
Front Back

3. What describes the nature of your symptoms?
- □ Sharp □ Shooting
- □ Dull ache □ Burning
- □ Numb □ Tingling

4. How are your symptoms changing?
- □ Getting Better
- □ Not Changing
- □ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None										*Unbearable*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)
□ All of the time □ Most of the time□ Some of the time □ A little of the time □ None of the time

7. In general would you say your overall health right now is...
□ Excellent □ Very Good □ Good □ Fair □ Poor

8. Who have you seen for your symptoms?
□ No One □ Chiropractor □ Medical Doctor □ Physical Therapist □ Other

a. What treatment did you receive and when? ____

b. What tests have you had for your symptoms and when were they performed?
□ Xrays *date:* ______________ □ CT Scan *date:* ______________
□ MRI *date* ______________ □ Other *date:* ______________

9. Have you had similar symptoms in the past? □ Yes □ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
□ This Office □ Medical Doctor □ Other
□ Chiropractor □ Physical Therapist

10. What is your occupation?
□ Professional/Executive □ Laborer □ Retired
□ White Collar/Secretarial □ Homemaker □ Other
□ Tradesperson □ FT Student

____

a. If you are not retired, a homemaker, or a student, what is your current work status?
□ Full-time □ Self-employed □ Off work
□ Part-time □ Unemployed □ Other

11. What is your: Height________Feet_______Inches ***Weight***____________Pounds

Patient Signature____***Date***______________________

Patient Name____ ***Date***____________________

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What alleviates your problem?

____

16. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

17. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Visual Disturbances
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Dizziness
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Asthma
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Chronic Sinusitis
□	□ Arthritis	□	□ Hepatitis	**For Females Only**	
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Birth Control Pills
□	□ Cancer	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Tumor	□	□ Muscular Incoordination	□	□ Pregnancy
□	□ Other: ____________________________				

19. List all prescription medications you are currently taking:

____

20. List all of the over-the-counter medications you are currently taking:

____

21. List all surgical procedures you have had:

____

22. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

23. What activities do you do outside of work?

____

24. Have you ever been hospitalized? □ No □ Yes if yes, why____

25. Have you had significant past trauma? □ No □ Yes Describe____

Patient Signature____ ***Date***____________________