

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

Please fill in ALL portions of the form. If you need assistance, please ask.

Your Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Pager: _____ Cell Ph: _____

Age: _____ Date of Birth: _____ SS #: _____ E-mail: _____

Marital Status (circle one): M S D W Drivers License #: _____

Your Occupation: _____ Employed by: _____

Work Phone #: _____ Work Address: _____

Your Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work #: _____

Name of person to contact in case of emergency: _____

Their phone number: _____

Name of nearest relative not living with you: _____

Their phone number: _____

Who referred you to this office so we may thank them? _____

Referring Physician: _____

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: _____ Date: _____

Parent or Guardian: _____

Witness Signature: _____ Date: _____

Is your visit due to an accident? (circle one) YES NO

Please complete the information on the next page. Thank you!

Medical Insurance:

Insurance Carrier: _____ Address _____

Phone: _____ Policy Holder Name: _____

Policy Number: _____ Group Number: _____

If Applicable Workers Compensation Injury:

Employer: _____ Work Number: _____

Address: _____ Supervisor: _____

Was injury/accident reported to supervisor? Y / N Date: _____ Time: _____

Workers Comp Carrier: _____ Adjuster: _____

Claim Number: _____

If Applicable Auto / Personal Injury:

Do you have "Med Pay" on your Auto Policy? Y / N Amount: \$ _____

Insurance Carrier Name: _____ Phone Number: _____

Adjuster: _____ Claim Number: _____

Third Party Payer (other involved vehicle insurance):

Third Party (Person at Fault's) Name: _____ Ph: _____

THEIR Insurance Carrier: _____ Ph: _____

Address: _____

Adjuster: _____ Claim Number: _____

Please complete the information on the next page. Thank you!

Headache	Feet/hands cold	Head seems heavy	Pins and needles in arms Right / Left
Mental dullness	Depression	Confusion	Pins and needles in hand Right / Left
Loss of memory	Pins and needles in arms	Constipation	Pins and needles in legs Right / Left
Dizzy	Rib pain	Unbalanced	Neck pain
Neck stiffness	Chest pain	Fainting	Shortness of breath
Ears ringing / buzzing	Upper back pain	Upper back stiffness	Mid-back pain
Mid-back stiffness	Lower back pain	Lower back stiffness	Blurred vision
Double vision	Neck restriction	Eye strain / pain	Loss of taste
Loss of smell	Nervousness	Fear	Tension / Irritability

(Please circle all that apply)

Difficulty in: Standing, Bending, Walking

Pain radiation to the: Right arm, Left arm, Right leg, Left leg

Cannot lift: Light, Moderate, Heavy, Repetitive

Pain radiation to: Neck, Base of skull, Ribs, Shoulders, Arms

Pain in the: Foot, Ankle, Hip,

OTHER: _____

Has the problem interrupted your sleep? Y / N How: _____

Does anyone in your family have the same or similar condition: Y / N Who: _____

List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____

2. _____ Specialty _____

Relevant medical history: (Please circle the conditions you have or had previously)

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasms
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Polio
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	TB
Dizziness	Multiple sclerosis	Venereal disease

Please complete the information on the next side. Thank you!

List any operations that you've had and approximate dates:

- 1. _____ Date: _____
Dr. _____
- 2. _____ Date: _____
Dr: _____
- 3. _____ Date: _____
Dr: _____
- 4. _____ Date: _____
Dr: _____

Are you allergic to any medication? Please list:

Are you taking any medications? Please list:

Do you wear Orthotics (shoe inserts)? YES / NO

If yes, what type?

Are you pregnant? YES / NO Due date: _____

Do you: Smoke: YES / NO Amount per day: _____

Drink: YES / NO Light Medium Heavy

Exercise: Never Sometimes Frequently Regularly

Does anyone in your family have a similar health related problem? YES / NO

Who: _____ What condition:

Care they are receiving:

Patient Name: _____ Date: _____