CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

REFERRED BY: ________________________________ Email Adress:____

1. LAST NAME ___________________________________ FIRST NAME ___________________________________ 3. MI ______
4. ADDRESS ____
5. CITY ____ 6. STATE ____________________ 7. ZIP_____________
8. HOME (_____) ___________________ 9. WORK (_____)___________________ 10. CELL (_____) ___________________
11. AGE ____ 12. DATE OF BIRTH ______/______/______ 13. SEX ☐ M ☐ F 14. SOC. SEC.# ______-______-______
15. MARITAL STATUS ☐ S ☐ M ☐ D ☐ W 16. SPOUSE'S NAME ____
18. PRIMARY CARE PHYSICIAN:____

ADDRESS:____

TELEPHONE: (_____) ______________________________ FAX: (_____) __________________________

WORKERS COMPENSATION / SCHEDULED LOSS INFORMATION

2. EMPLOYER & OCCUPATION ____
2. ADDRESS ____
3. CITY ____ 4. STATE ____________________ 5. ZIP ________________
8. BUSINESS PHONE # (_____) ________________________________ 9. FAX # (_____)______________________________
10. **(SCH. LOSS EXAMS)** DO YOU HAVE: ☐ SURGICAL REPORTS ☐ X-RAY REPORTS ☐ MRI REPORTS

AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. INSURANCE TYPE: ☐ AUTO ☐ WORK ☐ LIEN ☐ ____
2. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ ___________________________________
3. DATE OF INJURY _________________ 4. DESCRIBE HOW INJURY OCCURED? ____________________________________

____

6. WHICH BODY PART(S) WERE INJURED? ____
7. NAME OF INS. CO. ____ 8. INS. PHONE (_____)____________________
9. INS. CO. ADDRESS ____
10. POLICY # ________________________ 11. CLAIM # _________________________ 12. WCB #____________________
13. DID YOU REPORT INJURY? ☐ NO ☐ YES IF YES, TO WHOM?____
14. HOSPITALIZED? ☐ NO ☐ YES WHERE?_________________ 15. X-RAYS TAKEN ☐ NO ☐ YES BY WHOM ____________
16. WHERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐ NO ☐ YES
17. ARE YOU PRESENTLY WORKING? ☐ NO ☐ YES IF NO, DATES LOST FROM WORK ______________________
18. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY ____
19. IF AUTO INJURY, WERE YOU? ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐______________________________
20. # OF PEOPLE IN YOUR VEHICLE? _____ 21. WORE SEAT BELT? ☐ NO ☐ YES 22. DID AIRBAG INFLATE ☐ NO ☐YES
23. NAME OF ATTORNEY ____

ATTORNEY ADDRESS:____

ATTORNEY TELEPHONE: (_____) __________________________ ATTORNEY FAX: (_____) _______________________

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. INSURED'S NAME ____ 2. INSURED'S SS# ______/______/______
3. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _________________________________
4. NAME OF INSURANCE CO. ____
5. ADDRESS ____
6. INSURANCE PHONE # (_____)________________________ 7. POLICY # _____________________________________

SECONDARY INSURANCE 8. INSURED'S NAME __________________________________ 9. SS # _____/_____/_____

10. NAME IS INSURANCE CO. ____
11. ADDRESS ____
12. INSURANCE PHONE # (_____) ________________________ 8. POLICY # ______________________________________

Confidential Patient Questionnaire

Name: ______________________ Date: __________

Major Complaint(s): ______________________________

CHECK YOUR PRESENT AND PAST SYMPTOMS

Present	Past		Present	Past	
☐	☐	Neck Pain	☐	☐	Excessive Thirst
☐	☐	Middle Back Pan	☐	☐	Chronic Cough
☐	☐	Low Back Pain	☐	☐	Sinus Problems
☐	☐	Headache	☐	☐	Chronic Fatigue
☐	☐	Dizziness	☐	☐	Painful Urination
☐	☐	Convulsions	☐	☐	Frequent Urination
☐	☐	Fainting, Visual Problems, Nausea	☐	☐	Difficulty with Bladder/Bowels
☐	☐	Shoulder Pain	☐	☐	Stomach Pain
☐	☐	Pain in Shoulder, Arms, Elbows	☐	☐	Difficult Swallowing
☐	☐	Pain in Hands	☐	☐	Depression
☐	☐	Pain in Upper Leg	☐	☐	High Blood Pressure
☐	☐	Pain in lower Leg	☐	☐	Angina
☐	☐	Pain in Ankle/Foot	☐	☐	Heart Attack
☐	☐	Swelling/Stiffness in Joints	☐	☐	Stroke
☐	☐	Jaw Pain	☐	☐	Asthma
☐	☐	Ringing in Ears	☐	☐	Cancer
☐	☐	Rapid Heart Beat	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Arthritis
☐	☐	Loss of Appetite	☐	☐	Diabetes
			☐	☐	Ulcers

Please describe your current pain: __ Sharp __Dull __ Aches __Sore __Weak __ Throbbing
__Shooting __Constricting __Burning __Tingling

Was your problem from a: __Car Accident __Work Related Injury __Started Gradually __Slip and Fall __Other

Describe how the problem began: ______________________________

What treatment have you received for this condition: __Family Doctor __Chiropractic __ Physical Therapy
__Medical Specialist __Surgery __Injections __X-Ray __MRI Other________________

Have you ever had this problem before? __ Yes __No

What makes the problem better? __Nothing __ Lying Down __Walking __Sitting Other_________________________

What makes the problem worse? __Nothing __ Lying Down __Walking __Sitting Other_________________________

Are you currently working? __Yes __No
If yes, do you: ___Sit more then 50% of the day ___Light Manual Labor __Heavy Manual Labor

Does Your Problem Affect Your Daily Activities? __ No __Mild __Moderate __Significant Resretictions
Describe: ______________________________

Do you Smoke? __No __Yes ___Packs per Day

Do you Drink Alcohol? __No __Socially __Habitually

Patient or Legal Guardian Signature ______________________________

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Are you Pregnant? __No __Yes   Date of Onset of Last Menstrual Period ________________

Are you Currently Taking Medication? ___No __Yes Please List all Medicaltions ________________

Do you have Any Allergies to Drugs or Other Products? __No __Yes
Describe: ________________

FAMILY HISTORY

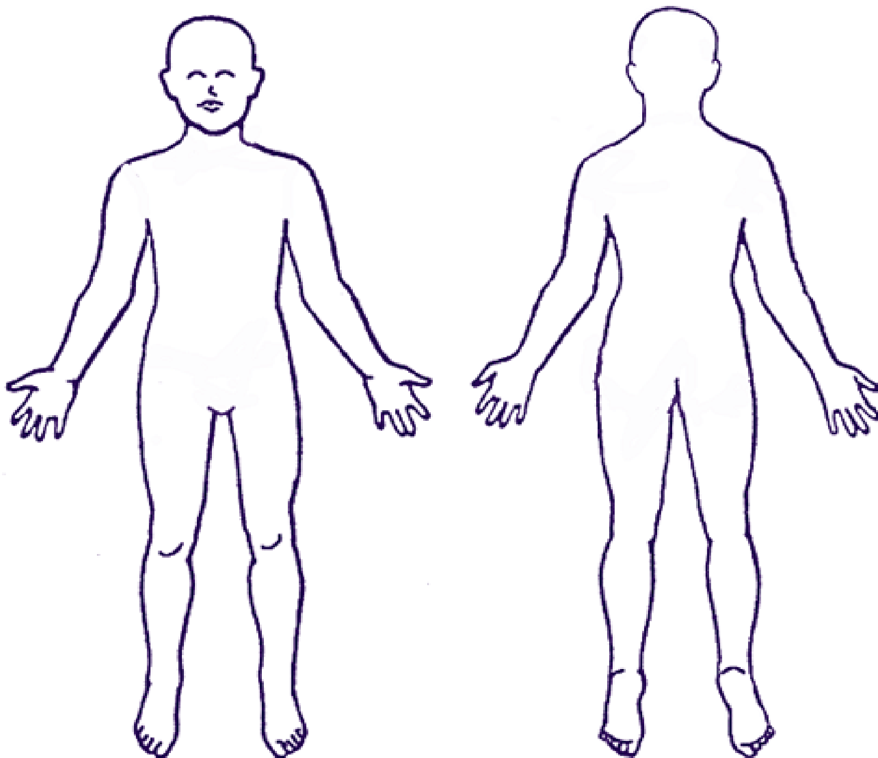
	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other	
Mother	☐	☐	☐	☐	☐	☐	☐	______
Father	☐	☐	☐	☐	☐	☐	☐	______
Brother	☐	☐	☐	☐	☐	☐	☐	______
Sister	☐	☐	☐	☐	☐	☐	☐	______
Grandmother	☐	☐	☐	☐	☐	☐	☐	______
Grandfather	☐	☐	☐	☐	☐	☐	☐	______

Current Work Status:

- ☐ I Have Not Missed Any Days of Work
- ☐ I Have Missed ___ Days of Work
- ☐ I Have Been Put on Light Duty at Work
- ☐ I Have Had to Change my Job as a Result of my Condition

PAIN / SYMPTOM PICTURE

Please mark with an "X" where you have any symptoms



Patient or Legal Guardian Signature ________________

Date: ____________________