CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

Please fill in ALL portions of the form.

If you need assistance, please ask our receptionist

Your Name:______________________________________ Date:________________
Address: ________________________City:___________ State: _____Zip: _________
Home Phone #: ___________ Pager: __________ Cell Ph: ____________
Age: ____ Date of Birth: ________ SS#: _________________ E-mail: ______________
Marital Status: M S D W Drivers License # _____________________
Your Occupation:____________________ Employed by:_________________________
Phone #:_______________ Address: _________________________________
Is your visit due to an accident? Yes / No
Are you are Medicare Patient? Yes / No Medicare #: __________________________
Your Spouse's Name:____
Spouse's Employer: _________________ Spouse's work phone #: _________________
Name of person to contact in case of emergency:_______________________________
Their home and work phone number:______________________________________
Name of nearest relative not living with you:__________________Phone #:_____________
Who referred you to this office so we may thank them? _______________________
Referring Physician: ____
In order to determine if care can be of benefit to you, this office will extend the courtesy of an initial consultation without charge. If the doctor might be able to help you with your condition, are you interested in seeking care? Yes Unsure

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: ____
Signature: ____ Date ______

Insurance Coverage Information

Medical Insurance:

Insurance Carrier: ______________________________ Phone: ______________
Policy Holder name: _____________________ Policy Number: ______________
Group Number: __________________

Workers Compensation Injury:

Employer: ______________________________ Work Number: ______________
Address: _________________________________ Supervisor: ________________
Was injury/accident reported to supervisor Y / N Date: _________ Time: ________
Workers Comp Carrier: ______________________________ Policy #: __________
Carriers Phone: _______________ Adjuster: ______________________________
Claim Number: ________________

Auto / Personal Injury:

Do you have "PIP" or "Med Pay" on your Auto Policy: Yes / No Amount: $ ______________
Insurance Carrier Name: _______________________ Phone: ________________
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 opposite side.

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Current Complaints (please circle the appropriate ones)

Headache	Feet/hands cold	Head seems heavy	Pins and needles in arms Right / Left
Mental dullness	Depression	Confusion	
Memory loss	Weakness in arms	Constipation	Pins and needles in hands Right / Left
Dizzy	Rib pain	Unbalanced	
Neck Pain	Neck stiffness	Chest pain	Pins and needles in legs Right / Left
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	Irritability	Tension

Difficulty in: Standing, Sitting, Bending, Walking
Pain radiation to the: Right arm, Left arm, Right leg, Left leg
Cannot lift: Light Moderate, Heavy, Repetitive
Pain radiating to: Neck, Base of skull, Ribs, Shoulders, Arms
OTHER: ______________________________
Previous Treatments that helped ______________________________
Previous Treatments that Did Not ______________________________
Has the problem interrupted your sleep? Yes / No, How: ____________________
Does anyone in your family have the same or similar condition: Yes / No
Who: ______________________________
List any doctors or therapists that you have **seen for this complaint**:
1. ______________________ Specialty ____________
2. ______________________ Specialty ____________
3. ______________________ Specialty ____________

Relevant ***Medical History***: (Please circle the conditions you have or had previously)

Arthritis	Epilepsy	Muscular Dystophy
Asthma	Firomyalgia	Neck Pain
Anemia	Hand or wrist pain	Neuritis
Back Pain	Headaches	Numbness
Cancer	Heart problems	Polio
Contusion	Hepatitis	Rheumatic Fever
Convulsion	High Blood Pressure	Sinus Trouble
Diabetes	HIV	Sciatica
Digestive problems	Measles	TB
Dizziness	Multiple Sclerosis	Venereal disease

Are you taking any **Medications**?
____________ ____________
____________ ____________
____________ ____________
____________ ____________
____________ ____________
____________ ____________
____________ ____________
____________ ____________

List any **Surgeries** that you've had and approximate dates:
1. ____________ Date: ________ Dr: ____________
2. ____________ Date: ________ Dr: ____________
3. ____________ Date: ________ Dr: ____________
4. ____________ Date: ________ Dr: ____________

Family Health History
____
____
____
____
____
____
____

Are you allergic to any medication? Please list: ____________________
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: ____________________