New Patient Questionnaire

Patient Information

Patient I.D. _____

Please Print

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_____
Emergency Contact_____ Phone _____ Relation_____
Whom may we thank for referring you to us? _____
How did you hear about us?_____
Name of local primary Physician_____ May we contact them? Y / N

Insurance Information – If Insured, Please provide copy of insurance card

Is this visit due to: Auto Accident / Work Injury / Other _____

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
What other forms of treatment have you tried?(ice,heat,Tylenol,etc.) _____
Results?_____

Health History - Please circle all that apply

AIDS/ HIV	**Allergy Shots**	**Anemia**	**Anorexia**	**Appendicitis**	**Arthritis**	**Asthma**	**Bleeding**
Breast Lump	**Bronchitis**	**Bulimia**	**Cancer**	**Cataracts**	**Chicken pox**	**Depression**	**Diabetes**
Emphysema	**Epilepsy**	**Fractures**	**Glaucoma**	**Goiter**	**Gonorrhea**	**Gout**	**Heart dx**
Hepatitis	**Hernia**	**Herniated disc**	**Herpes**	**High Cholesterol**	**Kidney dx**	**Liver dx**	**Measles**
Migraines	**Miscarriage**	**Mono**	**M. S.**	**Mumps**	**Osteoporosis**	**Parkinson's**	**Polio**
Pacemaker	**Pneumonia**	**Prostate**	**Prosthesis**	**Implants**	**Rheumatoid**	**Stroke**	**Thyroid**
Tonsillitis	**Tuberculosis**	**Tumors**	**Typhoid**	**Ulcers**	**V. D.**	**Whooping Cough**	
Chronic Fatigue	**High Blood Pressure**	**Fibromyalgia**	**Other**_____				

Women - How many children?_____ Pregnant? YES/NO Date of last Menstrual Cycle_____
Nursing? YES/NO Taking Birth Control Pills? YES/NO

Previous Surgeries and Dates? _____
_____
List ALL Medications you are currently taking _____
_____
What kind of exercise do you do? _____
What supplements do you take?_____
How much do you smoke per day?_____ Drink 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 I will be responsible for any outstanding amount owed this office.

Patient Signature_____ **Date**_____