

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

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: _____

Their phone number: _____

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 _____

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

Present Complaints: (please circle the appropriate ones)

- | | | | |
|------------------|------------------------|----------------------|--|
| 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 needs in arms | Constipation | Pins and needles in legs
(Right / Left) |
| Dizzy | Rib pain | Unbalanced | Mid-back stiffness |
| Neck pain | Neck stiffness | Chest pain | Double vision |
| Fainting | Shortness of breath | Ears ringing/buzzing | Loss of smell |
| Upper back pain | Upper back stiffness | Mid-back pain | Tension |
| Lower back pain | Lower back stiffness | Blurred vision | |
| Neck restriction | Eye strain/pain | Loss of taste | |
| Nervousness | Fear | Irritability | |

Difficulty in: Standing, Sitting, Bending, Walking

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

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

OTHER: _____

Cannot lift: Light, Moderate, Heavy, Repetitive

Pain in the: Foot, Ankle, Knee, Hip, Heel spurs

Since the time this (these) complaint(s) began, what, if anything, have you tried that did not work?

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: _____

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

- | | | | |
|----------------------|------------------------|---------------------|-------------------------|
| Anemia | Digestion problems | High blood pressure | Numbness |
| Arthritis | Dizziness | HIV / AIDS | Polio |
| Asthma | Epilepsy | Kidney problems | Rheumatic Fever |
| Back pain or spasm | Fibromyalgia | Measles | Sciatica |
| Balance problems | Hand or wrist pain | Multiple Sclerosis | Seizures |
| Cancer | Headaches | Muscular Dystrophy | Sensitivity to heat/ice |
| Circulatory problems | Hearing problems | Neck pain or spasms | Sinus trouble |
| Concussion | Heart problems/disease | Nervous disorders | TB |
| Convulsion | Hepatitis | Neuritis | Venereal disease |
| Diabetes | Hernia | Neuropathy | Vision problems |

Patient Name: _____ Date: _____

Do you currently have any metal implants? Yes / No

Do you currently have a pacemaker? Yes / No

Do you have any communicable disease? Yes / No

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: _____

Is it helping? Yes / No

May we contact them regarding their condition? Yes / No

Patient Name: _____ Date: _____