

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can serve you better. Please fill in as much information as possible, even if it does not apply to your current medical complaints. If you need any help filling this form out, we would be happy to assist you.

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____ S.S.# _____ - _____ - _____

Date of Birth ____/____/____ Age: _____ Marital Status: M S D W

Employer: _____ Occupation: _____

Work Phone: _____ Address: _____

Spouse's Name: _____ Their Primary Phone#: _____

Emergency Contact: _____ Their Primary Phone#: _____

Who referred you to this office/how did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Identification #: _____ Group #: _____

Policy Holder Name: _____

*This office will be happy to file your claim to your Primary Carrier but we do not file to Secondary Carriers (Except on Medicare Claims).

Is this visit due to an Auto or Work related injury? Yes / No

We are happy to offer a consultation at no charge. Examinations and Treatments are charged services. Please inform us if you wish to receive a consultation only.

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 Signature: _____ Date: _____

Parent or Guardian: _____

Parent or Guardian Signature: _____ Date: _____

Current Primary Complaint

Please provide as much information as possible

1. What condition/complaint are you here for? _____
2. Describe its exact location. _____
3. When did it begin? _____
4. Did it start suddenly, gradually or develop over time? _____
5. What caused it? _____
6. Describe the quality of the pain. (ie. Sharp, dull, aching, throbbing, etc.) _____
7. Is it constant, frequent, intermittent or occasional? _____
8. What makes it worse? (ie. Bending, lifting, standing, etc) _____

9. What makes it feel better? _____
10. Does the pain radiate? If yes, where? _____
11. Try to rate your pain between 0 and 10. ___ / 10 average ___ / 10 at best ___ /10 at worst
12. Does it change throughout the day? _____
13. Does it interrupt your sleep? If yes, how often per night? _____
14. Do you experience any numbness or tingling? If yes, where? _____
15. Have you taken any over-the-counter meds for it? What? _____
16. Have you seen any other doctors or therapists for this complaint? Who? _____

17. What have you tried that has not helped your complaint? _____
18. Do you have any other complaints? List: _____

Medical History

Please circle anything you have had in the past.

- | | | | |
|---------------------|----------------------|-----------------|-------------------|
| Anemia | Arrhythmia | Arthritis | Asthma |
| Back Pain | Sciatica | Broken Bones | Cancer |
| Depression/Anxiety | Diabetes | Eating Disorder | Emphysema |
| Epilepsy | Gall Bladder Problem | Glaucoma | Gout |
| Headaches | Heart Disease | Heart Murmur | Heel Spurs |
| High Blood Pressure | Kidney Stones | Liver Disease | Lung Disease |
| Mental Disorder | Neuropathy | Osteopenia | Osteoporosis |
| Paralysis | Pneumonia | Tendonitis | Dislocations |
| Prostate Problems | Reflux/Ulcers | Rheumatic Fever | Rheumatoid Arthr |
| Seizures/Epilepsy | Sickle Cell | Stroke | Thyroid Disease |
| Tuberculosis | Concussions | GI Problems | Numbness |
| Sinus Trouble | Allergies | Weakness | Bleeding Disorder |

Surgical History

Please list any surgeries and their approximate dates.

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

Social History

Do you: Smoke Y / N Amount per day? _____
 Drink Y / N How often per week? _____
 Exercise Y / N How often per week? _____
 Work at Desk Y / N How much per day? _____
 Work on Phone Y / N How much per day? _____
 Work Standing Y / N How much per day? _____

Medication Information

Are you currently taking any medications? Please list them all and the condition they treat.

Do you have any allergies to medication or anything else? List: _____

Does anyone in your family suffer from any significant health conditions, such as cancers, heart problems, diabetes, arthritis? _____

Do you wear orthotics? Brand? _____

Is there any further information you think we should know? _____

Patient Signature _____ Date: _____