

# Health Questionnaire

## Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

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List any surgeries or hospitalizations you have had complete with the month and year for each:

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List anything you are allergic to: \_\_\_\_\_

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

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Do you exercise?  Yes  No Hours per week \_\_\_\_\_ What activity(s)? \_\_\_\_\_

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Are you dieting?  Yes  No Since: \_\_\_\_\_ Do you smoke?  Yes  No \_\_\_\_\_ packs per day.

How many years have you been smoking? \_\_\_\_\_ Do you drink alcoholic beverages?  Yes  No \_\_\_\_\_ drinks per day.

Do you wear?  Heal lifts  Arch supports  Prescription Orthotics

For women: Are you pregnant or nursing?  Yes  No If pregnant, How many weeks? \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

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## Medical History

Describe the reason(s) for your doctor visit today:

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Are you here because of an accident? \_\_\_\_\_ What type? \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_ How did your symptoms begin? \_\_\_\_\_

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? \_\_\_\_\_

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Have you experienced these symptoms in the past? \_\_\_\_\_

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## History of Treatment

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date last seen: \_\_\_\_\_ May we update them on your condition? \_\_\_ Yes \_\_\_ No

Have you seen a chiropractor before? \_\_\_ Yes \_\_\_ No Who referred you to us? \_\_\_\_\_

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: \_\_\_\_\_

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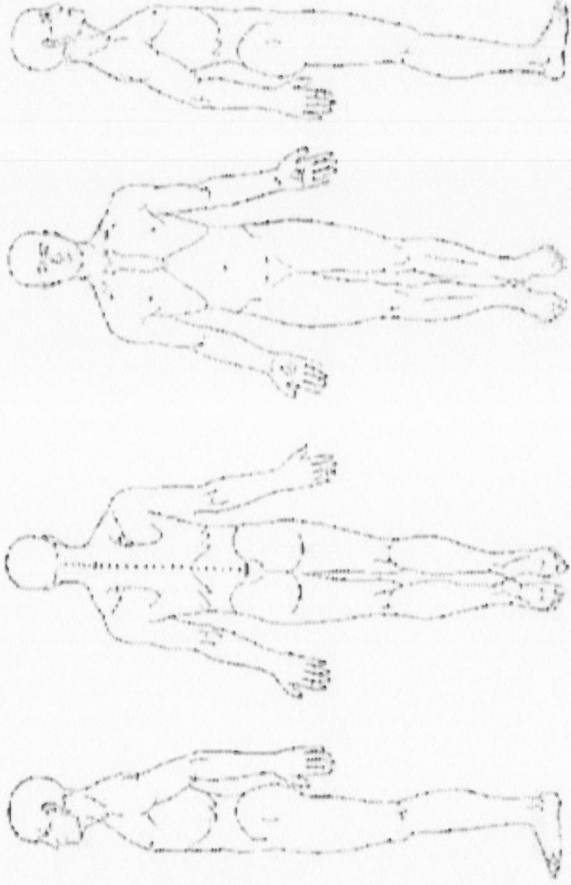
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## Description of Condition

Mark any area(s) of discomfort with the following key:

A = Ache N = Numbness B = Burning T = Tingling S = Stiffness O = Other



Left

Back

Front

Right

On a scale of one to ten how intense are your symptoms? Not intense ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable



For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Elbow/upper arm pain	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder
<input type="radio"/>	<input type="radio"/>	Abnormal Weight gain/loss	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control
<input type="radio"/>	<input type="radio"/>	Allergies Headache	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Low back pain
<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>	Mid back pain
<input type="radio"/>	<input type="radio"/>	Ankle/foot pain	<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Neck pain
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Hand pain	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Shoulder pain
<input type="radio"/>	<input type="radio"/>	Birth Control Pills	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Smoking/tobacco Use
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Hip/upper leg pain	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Systematic Lupus
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Thoracic Outlet Syndrome
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Jaw pain	<input type="radio"/>	<input type="radio"/>	Tumor
<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Joint swelling/stiffness	<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Upper back pain
<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Knee/lower leg pain	<input type="radio"/>	<input type="radio"/>	Wrist pain

Additional comments you would like the doctor to know: \_\_\_\_\_

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Patient's signature: \_\_\_\_\_ Doctor's signature: \_\_\_\_\_

## Patient Intake Form

### Patient Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Female: \_\_\_\_\_ Male: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Other: \_\_\_\_\_

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age 18/Single/Married/Divorced/Widowed/Separated

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

### Payment Information

Person Responsible for Payment: \_\_\_\_\_

Social Security Number:   N/A   Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Insurance Information

Do you have health insurance?  Yes  No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

**Please have your insurance card and driver's license ready so they can be copied for the clinic's records.**

### Consent for Treatment

*Assignment & Release - By signing below, I authorize [Complete Wellness Center, S.C.] to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to [Complete Wellness Center, S.C.] and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

*By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient*

Signed \_\_\_\_\_ Date \_\_\_\_\_