

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 _____

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 "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: _____

Patient Name: _____ **Date:** _____

Present Complaints (please circle the appropriate ones) Page 3

- | | | | |
|------------------|--------------------------|----------------------|---------------------------|
| Headache | Feet/hands cold | Head seems heavy | Pins and needles in arms |
| Mental dullness | Depression | Confusion | Right / Left |
| Loss of memory | Pins and needles in arms | Constipation | Pins and needles in hands |
| Dizzy | Rib pain | Unbalanced | Right / Left |
| Neck Pain | Neck stiffness | Chest pain | Pins and needles in legs |
| Fainting | Shortness of breath | Ears ringing/buzzing | Right / Left |
| Upper back pain | Upper back stiffness | Midback pain | Midback 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

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

OTHER: _____

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 _____
3. _____ Specialty _____

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

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasms
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Polio
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	TB
Dizziness	Multiple sclerosis	Venereal disease

Patient Name: _____ **Date:** _____

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:** _____