Florida Chiropractic

New Chiropractic Patient Questionnaire

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

E-Mail address: _____ SSN #: _____

Married ____ Single ____ Widowed ____ Divorced ____ # of Children ____

Spouse: _____ Employment: _____

Whom may we thank for referring you to us? _____

Personal Habits

Are you currently using any: ____Medications ____ Drugs ____ Tobacco ____ Alcohol
____ Coffee ____ Vitamins/Minerals/Herbs ____ Exercise

List all medications you are currently taking _____

_____

Present Health Condition

Height _____ Weight _____ Have you experienced any significant weight change in the past three months? ___ Yes ___ No

If yes, please describe change _____

Please list your symptoms below in order of importance and give date symptoms began.

1._____Date_____

2._____Date_____

3._____Date_____

4._____Date_____

Is this condition due to an auto accident? ___Yes___No If yes, date of accident_____ State of Accident: _____

Is this condition a direct result from an injury which occurred at work? __Yes __No

If yes, date and time of injury _____ Did you report this injury to your employer?__Yes__No

Relative to Contact in Case of Emergency:

Name: _____ Daytime phone #_____ Relationship to Patient: _____

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Florida Chiropractic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____Date_____

Please complete Health History on next page

Health History

Patient Name: _____ Today's Date: _____

Have you ever had the same or similar symptoms? ___Yes___No If yes, when? _____
Have you had treatment by another doctor for these symptoms? ___Yes___No
If yes, name of doctor _____
Is there any family history of this type of pain? ___Yes___No
Have you had any previous Chiropractic care? ___Yes___No
Have you ever been hospitalized? ___Yes___No If yes, when and why? _____
Have you ever broken any bones? ___Yes___No If yes, when and what? _____
Have you noticed any recent changes in bowel or bladder habits? ___Yes___No. If yes, please describe _____
_____

Please check below if you or a member of your family has ever been diagnosed with or suffered from:

You	Family	Relationship (Father, Mother, Sister, etc ...)	
_____	_____	_____	1. Cancer
_____	_____	_____	2. Diabetes
_____	_____	_____	3. Thyroid Disease
_____	_____	_____	4. Hypertension (High Blood Pressure)
_____	_____	_____	5. Hypercholesterolemia (High Cholesterol)
_____	_____	_____	6. Atherosclerosis (Heart Disease)
_____	_____	_____	7. Kidney Disease
_____	_____	_____	8. Osteoporosis
_____	_____	_____	9. Neuromuscular Disease (i.e. Parkinson's, Multiple Sclerosis)
_____	_____	_____	10. Rheumatoid arthritis
_____	_____	_____	11. Allergies/Asthma
_____	_____	_____	12. Scoliosis
_____	_____	_____	13. Low back pain/or surgery
_____	_____	_____	14. Headache/Migraine
_____	_____	_____	15. Gastrointestinal Problem (Gallbladder, Ulcers, Diverticulitis)
_____	_____	_____	16. Liver Disease (Hepatitis, Cirrhosis)
_____	_____	_____	17. Other _____

Please notify the Doctor if you suffer from any medical condition not listed on this form.

Female Health History

Date of last menstrual cycle_____ Was it ___regular or ___irregular?
Is there any possibility that you are pregnant? ___Yes___No___Maybe
Are you using some form of birth control? ___Yes___No If yes, what kind _____
Do you have an annual gynecological exam? ___Yes___No
If over 40, do you have a regular mammogram? ___Yes___No
Do you have a regular thermogram? ___Yes___No

Male Health History

Do you have a regular prostate exam? ___Yes___No
Have you had a recent Prostate Specific Antigen test? ___Yes___No

Primary Care Provider

Do you have a primary care physician? ___Yes___No.
Doctor's name: _____ Phone #: _____