

# QUESTIONNAIRE FOR TREATMENT

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

Doctor referred to: \_\_\_\_\_ Referred by: \_\_\_\_\_

## 1. REASON FOR VISIT:

List your chief complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did this episode begin? \_\_\_\_\_

**DRAW PAIN AREAS BELOW ↓**

How did it occur?      Gradually      Suddenly

XXX = PAIN      // = NUMBNESS

Describe: \_\_\_\_\_  
\_\_\_\_\_

Is it:    Worse    Better    Intermittent    Constant    Daily  
Have you had this or similar problems in the past?    Yes    No  
If yes, when? \_\_\_\_\_

When is it worse?    AM    PM    Night  
With what does it interfere?    Work    Sleep    Daily routine

Other: \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

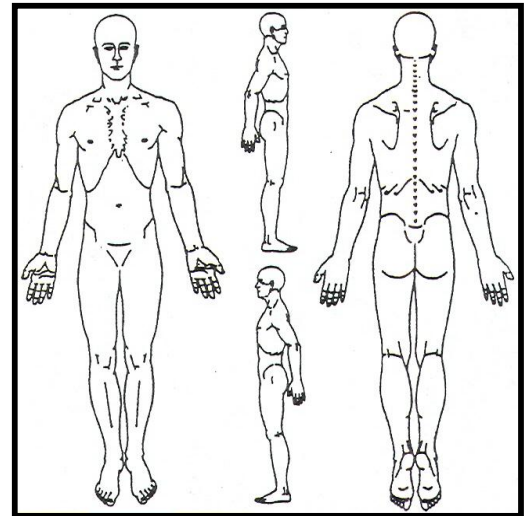
Do you have pain/numbness in the arms, legs, hands or feet?  
Yes    No    Where and what type? \_\_\_\_\_

Have you seen any other doctors for this problem?    Yes    No  
If yes, doctor's name: \_\_\_\_\_

What type of physician?    Chiropractic    Medical    Other    Most recent visit date: \_\_\_\_\_

What did they recommend? \_\_\_\_\_

On a scale of 0 to 10, with 10=extreme pain and 0=no pain, **rate your average pain level:** \_\_\_\_\_



## 2. PAST HEALTH HISTORY:

Drugs you now take:    Pain Killers    Muscle relaxers    Blood pressure    Birth control  
Other: \_\_\_\_\_

List all surgeries you have had and when: \_\_\_\_\_  
\_\_\_\_\_

List all allergies \_\_\_\_\_  
\_\_\_\_\_

Prior Injuries (please circle location and describe type of injury):  
Shoulder / Arm / Elbow / Wrist / Hand / Finger / Hip / Leg / Knee / Ankle / Foot / Toe  
Head / Spine / Pelvis  
Describe injuries: \_\_\_\_\_  
\_\_\_\_\_

Which (if any) of the above injuries still bother you? \_\_\_\_\_  
\_\_\_\_\_

Have you ever experienced loss of consciousness? If so, describe: \_\_\_\_\_  
\_\_\_\_\_

Last auto accident:      Past year     Past five years     Over five years     Never



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First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

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

Sex: M F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Marital Status: M S D Email: \_\_\_\_\_

Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**EMPLOYER:**

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE CARRIER:** \_\_\_\_\_ Phone: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex: M F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**IS THIS INJURY N:**  Auto Accident  On-the-job Injury  Other

DOI: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Injury: \_\_\_\_\_:\_\_\_\_\_ AM PM

How Referred to Office: \_\_\_\_\_

Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Appointment Time: \_\_\_\_\_:\_\_\_\_\_ AM PM

Chief Complaint: \_\_\_\_\_

**Patient Health Information Consent Form:**

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a compliance officer has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

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Information about family members will give us a better picture of your total

health.

<u>NAME</u>	<u>RELATION</u>	<u>PAST AND PRESENT HEALTH PROBLEMS</u>

## 4. YOUR HEALTH HISTORY

**C = Current, P = Past**

### General

- C P Allergy
- C P Convulsions
- C P Dizziness
- C P Fainting
- C P Headache
- C P Sudden weight loss

### Muscle & Joint

- C P Arthritis
- C P Bursitis
- C P Low back pain
- C P Neck pain/stiffness
- C P Pain between shoulders
- C P Spinal Curvature

### Eyes, Ears, Nose & Throat

- C P Deafness
- C P Earache
- C P Failing Vision
- C P Nosebleeds
- C P Sinus infections
- C P Strep throat

### General-Intestinal

- C P Colon trouble
- C P Constipation
- C P Diarrhea
- C P Gall Bladder trouble
- C P Hemorrhoids
- C P Hernia
- C P Liver trouble
- C P Nausea

### Respiratory

- C P Asthma
- C P Chest Pain
- C P Chronic cough
- C P Spitting up blood

### Pain or numbness in

- C P Shoulders/Arms
- C P Elbows/Hands
- C P Hips/Legs
- C P Ankles/Knees/Feet

### Skin problems

- C P Bruise easily
- C P Hives or allergy
- C P Skin rash

### Other

- C P Diabetes
- C P Alcoholism
- C P Anemia
- C P Cancer
- C P Measles
- C P Stroke
- C P Rheumatic fever
- C P Sex trans disease
- C P Gout
- C P Mumps
- C P Polio

### Cardio-Vascular

- C P Hardening of arteries
- C P High blood pressure
- C P Low blood pressure
- C P Rapid/slow heart beat
- C P Swelling of ankles

### Genital-Urinary

- C P Bed-wetting
- C P Frequent urination
- C P Kidney infection
- C P Painful urination
- C P Prostate trouble

### For Women Only

- C P Cramps or backaches
- C P Excessive menstrual flow
- C P Irregular cycle
- C P Lumps in breast
- C P Post menopause Syndrome

### Psycho-Social

- C P Depression
- C P Anxiety
- C P Sleep disturbances
- C P Chronic fatigue
- C P Divorce
- C P Death
- C P Family problems
- C P Economic
- C P Drugs/Alcohol
- C P Change in job status
- C P Work problems

Check the appropriate box below:

#### Meals skipped:

Daily no. \_\_\_\_\_  
Weekly no. \_\_\_\_\_

#### Coffee-Daily

1-2 daily  
3-4 daily  
More

#### Alcoholic beverages

1-2 daily    1-2 weekly  
3-4 daily    3-4 weekly  
More

#### Personal satisfaction w/diet

Highly satisfied  
Satisfied  
Highly unsatisfied

## IN CASE OF EMERGENCY (Name of relative or close friend not living at home):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Fees are payable at the time of x-rays, examination, and treatment(s) are received unless other arrangements are made in advance. X-rays remain the property of this clinic. I understand the above and hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of any combination of radiographs, manipulation (inclusive of my spine and extremities), therapy, rehabilitative exercises and acupuncture.

Patient Name (Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_