(Staff only) Name:	Account Number:	Date:

Application for Care

Patient Questionnaire

(The answers below will be part of your electronic file and are required by the US Government)

Your Legal Name: First: _____ Middle: _____Last: _____

Marital Status: _____ Spouse Name: _____

Gender: (circle) Male Female Date of Birth: _____

Social Security Number: (required by insurance) _____

Preferred method of contact (circle one): Email Home Phone Mail Cell Phone Text

Home Phone: _____ Cell: _____E-mail: _____

Street Address: _____ City: _____State: _____ Zip:_____

Ethnicity: (circle one) Non-Hispanic Hispanic other: _____

Preferred Language: (circle one) English Spanish German other: _____

Race (s): (check) ☐ Caucasian ☐ Asian ☐ African American ☐ Hawaiian ☐ Native American or ☐ native Alaskan

Family doctor: _____

Insurance

Self pay Medicare/Medigold General Insurance Workers Comp Personal Injury

Insurance Company: _____ Policy *: _____

ID number# _____Are you primary holder? (circle) Yes No
Insured name: _____Date of birth: _____
Secondary insurance: (circle) no yes _____
Optional (fill out this section if your problems are due to a work injury or car accident)
BWC claim number: _____Date of injury:_____
Attorney Name: _____ Date of accident: _____

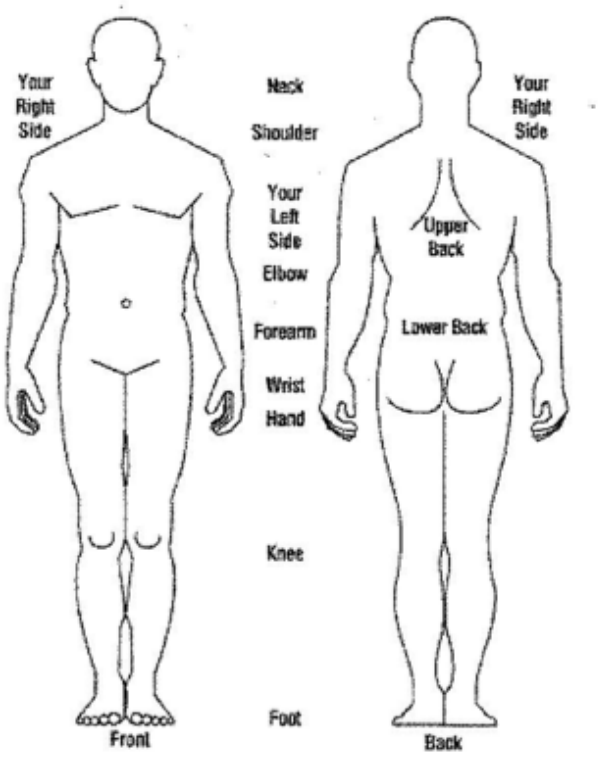
(Staff only) Name:	Account Number:	Date:

Complaints:

1. Please describe your problems/complaints: _____
   _____
2. What caused your problem(s)? _____
   _____
3. How long have your problems(s) been present? _____
4. What have you tried to treat your condition?
   _____
5. Have you seen any other health care providers for your problems? (circle) No Yes If yes, who and what was treatment? _____
6. Please rate your pain on a scale from 0-10 where 0 is no pain and 10 is unbearable pain.
   Area: _____rating _____/10, Area: _____rating _____/10
   Area: _____rating _____/10, Area: _____rating _____/10
   Area: _____rating _____/10, Area: _____rating _____/10
7. Does your pain radiate to your arms or legs? (circle) No Yes If yes, where? _____
   _____
8. How often is your pain present? Write your complaints next to the frequency that fits the best.
   Constant (present 76-100%) _____
   Frequent (present 51-75%) _____
   Occasional (present 26-50%) _____
   Intermittent (present 0-25%) _____
9. What position(s) or activities increase your pain? _____
10. What position(s) or activities decrease your pain? _____
11. Are you here for pain relief or pain relief and corrective care? _____

Please use the symbols to mark your symptoms on the bodies below.

Ache=A Burning = B Numbness = N Tingle = T Pins and Needles = P Other = O



(Staff only) Name:	Account Number:	Date:

Surgery / Hospitalizations

☐ I have not had any surgeries or never been in the hospital

Please list surgeries and the year performed and hospitalizations and the reason.

_____

_____

Past Medical History

(Check all that apply)

✓		✓		✓		✓	
	Anemia		Blood Clots		Gallbladder		Heart Attack
	Angina		Cancer		GERD		Osteoarthritis
	Anxiety		Stroke		Hepatitis C		Osteoporosis
	Arthritis		COPD		High Cholesterol		Gout
	Asthma		Coronary Disease		High Blood Pressure		Rheumatoid Arthritis
	Atrial Fibrillation		Cohn's Disease		Irritable Bowel		Dizziness
	Prostate Disease		Depression		Liver Disease		Fainting
	Kidney Disease		Diabetes		Migraines		
	Seizures		Thyroid Disease		Peptic Ulcer		

Review of Symptoms

(Check all that apply)

✓		✓	
	Night Sweats		Impotence
	Lack of energy		Pain in joints
	Unexplained weight loss or gain		Swelling in joints:
	Facial pain or numbness		Rashes
	Nose bleeds		Skin lesions
	Nasal drip		Hair loss/increase
	Mouth sores		Double vision
	Irregular heart beat		Poor balance
	Chest pains		Visual loss
	Swollen legs or feet		Tremors
	Pain in legs with walking		Headaches
	Shortness of breath		Anxiety
	Prolonged cough		Depression
	Coughing up blood		Intolerance to heat/cold
	Heart burn		Menstrual problems
	Constipation		Easy bruising
	Diarrhea		Frequent thirst
	Incontinence		Easy bleeding
	Painful or frequent urination		Blood diseases
	Prostate problems		Seasonal allergies
	Change in sex drive/energy level		Infections
	Anemia		Other:

(Staff only) Name:	Account Number:	Date:

Family History

Please check and identify the person in your family who has/had the condition

✓		✓	
	Cancer:		Heart Disease:
	Stroke:		Diabetes:
	Cystic fibrosis:		Back problems:
	Rheumatoid Arthritis:		High Blood Pressure
	Migraines:		Skin lesions:
	Lupus:		Other:

Social History

Number of Children: _____ Alcohol usage: drinks per day? _____ Caffeinated beverages per day _____
Tobacco usage: ☐ Never or _____packs/day for _____years. Date quit _____ (year)
Advance Directive: ☐ Yes ☐ No ☐ I do not know Do you use illegal drugs ☐ No ☐Yes
Employer: _____ Job title: _____
☐ Retired ☐ Unemployed ☐ Permanently Disabled if yes, when: _____

Level of Education: _____

Medications

☐ I have provided an updated list of medications and vitamins to the receptionist (no need to fill out info. below).

Please include prescription, over the counter medication and supplements/vitamins/herbs, etc. If you have an updated list of medications please provide that to the front desk so a copy can be made.
Here are y medications with does and date started: (Include amount of pills, strength and times per day you take)
Example: aspirin 80mg 1/day started (Date)

_____ / _____

_____ / _____

_____ / _____

_____ / _____

Allergies

☐ I **have no known allergies to medications, foods or environmental objects.**
Please list allergies to medications, environmental allergies and allergies to foods. Please give a brief description of the allergic reaction, when it started (year) and severity.
For example: Penicillin – Feb 2006, Skin rash- mild. Trees – Jan 2004, Itchy eyes- moderate
Medication allergies:

_____

Environmental allergies:

_____

Food allergies:

_____

I have read the information provided and answered the questions truthfully to the best of my knowledge, and hereby authorize this office to provide a chiropractic exam and if agreed on care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____