NEW CHIROPRACTIC PATIENT QUESTIONAIRE

Patient# _________ Date ____________________

NAME ____ DATE OF BIRTH _____________________
ADDRESS ____ HOME PHONE _____________________
CITY/ST/ZIP ____ CELL PHONE _______________________
OCCUPATION ____ WORK PHONE_____________________
Email____

MARRIED____SINGLE____WIDOW(R) ____DIVORCED____NUMBER OF CHILDREN____

SPOUSE __________________________ EMPLOYMENT ______________________________ WORK # ________________

Whom may we thank for referring you to our office? ____

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

Ht. _______ Wt._______ 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, list date of accident __________. Who was at fault? ___________

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.

In case of emergency who should we contact? Name _______________________ Daytime phone # __________________

Relationship ____

Family Chiropractic and Wellness Center is out of network with all insurance companies. We will be happy to file claims on your behalf for most policies, but no guarantee of payment or coverage can be made.

I certify that I, and/or my dependent(s), have insurance coverage with _______________________ and assign directly to ***Dr. Granka*** *all insured benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.*

I also understand that if I suspend/terminate my care, all fees for services will be immediately due. Payment is expected at time of visit.

Patient/Guardian Signature: ____ Date _______________________________

If under 18, parental consent require: I (please print) ______________________________________ give Family Chiropractic and Wellness Center Permission to treat my son/daughter with chiropractic care.

Parent/Guardian Signature: ____

Please Complete Health History on back of this page

Health History

Have you ever had the same or similar symptoms? ___ Yes ___ No. If yes, when? ___________________________________

Have you had treatment by another doctor and/or health practitioner for these symptoms? ___ Yes ___ No.

If yes name of doctor(s)/practitioner(s) ____

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 family member 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 and/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 pill? _____ 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

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: _______________________

Office Address: ____ FAX: _______________________

If you would like us to send any records from your visits at Family Chiropractic and Wellness Center to your primary physician, please ask for a release of records form at the front desk, and be sure to provide us with the doctor's name and fax number.

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