

# Performance Chiropractic

## CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

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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 #: \_\_\_\_\_ 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 \_\_\_\_\_

**Please complete the information on the opposite side. Thank you!**

**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

**Please complete the information on the opposite side. Thank you!**

**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

What are your goals for this visit? \_\_\_\_\_

Are you interested in learning about Wellness Care? Yes No Maybe

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_