CONFIDENTIAL PATIENT HEALTH QUESTIONNAIRE

Name: _____ DOB: ____ / ____ / _____ Age: _____ SS#: _____

Address: _____ City: _____ ST: _____ Zip: _____

Telephone (HOME) _____ (WORK) _____ (CELL/PAGER) _____

Marital Status: M S W D Spouse's Name: _____ # of Children: _____

Occupation: _____ Email: _____

Employer Name & Address _____

Who May We Thank For Referring You? _____

INSURANCE INFORMATION

Is Your Condition Relate To:

Work Injury? Yes No Date? _____

Auto Accident? Yes No Date? _____

Other _____

Do You Have Major Medical Insurance? Yes No

If Yes, Name Of Insurance Company:

_____

Policy Holders Name? _____

DOB _____ Relation To You? _____

Employer: _____

Identification Number _____

Have you had previous chiropractic care? YES NO

Main Complaint: _____

Other Complaints: _____

How Long Have You Had This Condition? _____

Have You Had Similar Conditions In The Past? YES NO

Other Doctors Seen For This Condition? _____

Are You Taking Any Medications? YES NO

If Yes, Please List: _____

_____

Have You Had Any Falls / Accidents / Surgery? YES NO

Please Describe: _____

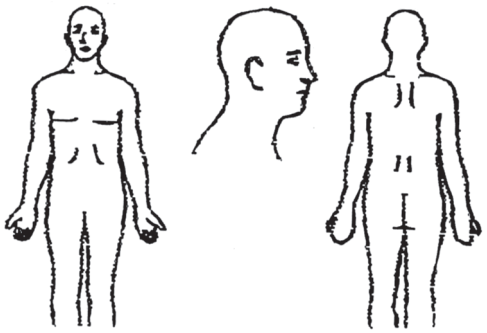
Date Of Last Physical Examination? _____

SYMPTOMS, CONDITIONS or HABITS, PLEASE CIRCLE YES or NO.

Abdominal Pain	Yes ..... No	Alcohol Dependence	Yes ..... No	Allergies	Yes ..... No
Anemia	Yes ..... No	Arm/Shoulder Pain	Yes ..... No	Arthritis	Yes ..... No
Back Pain	Yes ..... No	Bladder Problems	Yes ..... No	Chest Pain	Yes ..... No
Circulatory	Yes ..... No	Constipation	Yes ..... No	Depression	Yes ..... No
Diabetes	Yes ..... No	Digestive Disorder	Yes ..... No	Dizziness	Yes ..... No
Drug Dependence	Yes ..... No	General Fatigue	Yes ..... No	Nervousness	Yes ..... No
Headaches	Yes ..... No	High Blood Pressure	Yes ..... No	Hip or Leg Pain	Yes ..... No
Swollen Joints	Yes ..... No	Insomnia	Yes ..... No	Kidney Problems	Yes ..... No
Loose Stool	Yes ..... No	Low Blood Pressure	Yes ..... No	Lung/Bronchial Disorder	Yes ..... No
Morning Fatigue	Yes ..... No	Neck Pain	Yes ..... No	Hot Flashes	Yes ..... No
Poor Memory	Yes ..... No	Palpitation	Yes ..... No	Pregnant	Yes ..... No
Prostate Disorder	Yes ..... No	Sinus Trouble	Yes ..... No	Female Problems	Yes ..... No
Tobacco Use	Yes ..... No	Other Problems	_____		

FEMALES ONLY

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES TO THE SIDE



= = Numbness
O = Dull Ache
X = Burning
II = Sharp Stabbing
+ = Pin Needle
^ = Other

On a Scale from 1 - 10 Rate your level of PAIN 1 = PAINFREE & 10 = UNBEARABLE PAIN

OVER →

FAMILY HISTORY

RELATION	*NAME*	*AGE*	*PRESENT SYMPTOMS*	*PREVIOUS ILLNESS*
Mother				
Father				
Brothers				
Sisters				
Children				