CHIROPRACTIC HEALTH QUESTIONNAIRE

Patient Computer No.

Patient Chart No.

Physician
Chris Johnson, D.C.

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

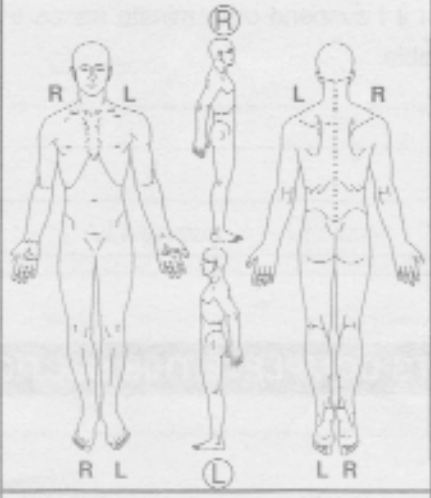
PATIENT NAME _____ TODAY'S DATE ____/____/____
FIRST MI LAST

A. MAJOR SYMPTOMS

1. What are your major symptoms?

- ○ Headache
- ○ Neck Pain
- ○ Upper Back Pain
- ○ Mid Back Pain
- ○ Low Back Pain
- ○ Shoulder Pain ☐ L ☐ R
- ○ Arm Pain ☐ L ☐ R
- ○ Buttock Pain ☐ L ☐ R
- ○ Hip Pain ☐ L ☐ R
- ○ Leg / Foot Pain ☐ L ☐ R
- ○ Radiating Pain
- ○ _____
- ○ Sleep Disturbance
- ○ Muscle Spasms
- ○ Bruises
- ○ Numbness
- ○ Tingling
- ○ Vision Problems
- ○ Anxiety / Nervousness
- ○ Jaw Pain / TMJ
- ○ Depression
- ○ Nausea
- ○ Dizziness
- ○ Restrictions of Movement

2. Shade in the areas where you feel discomfort or symptoms.



3. Sex ○ FEMALE: ARE YOU PREGNANT? ○ YES ○ NO ○ MALE

4. Describe your symptoms
(please answer A. B. C.)

A.
- ○ Constant
- ○ Comes and Goes

B.
- ○ Gradual Onset
- ○ Sudden Onset

C.
- ○ Aches
- ○ Sharp
- ○ Dull
- ○ Burns
- ○ Spasm
- ○ Throbbing
- ○ _____
- ○ _____

5. What caused your present symptoms?
- ○ Auto Accident
- ○ On-The-Job Injury
- ○ Unknown
- ○ Other _____

6. Date your "present" symptoms began?

MONTH DAY YEAR
_____/_____/_____

7. What aggravates your condition?
- ○ Coughing
- ○ Straining
- ○ Standing
- ○ Sitting
- ○ Walking
- ○ Bending
- ○ Other _____

8. Have you been examined or treated for your "present" symptoms?
- ○ *No Examination or Treatment*
- ○ Yes (Please list)
  - ○ Rex Hospital ER
  - ○ Duke Health Raleigh Hosp. ER
  - ○ Wake Medical Center ER
  - ○ Family M.D. Dr. _____
  - ○ Chiropractor Dr. _____
  - ○ Physical Therapy _____
  - ○ Other _____
  - ○ Other _____
  - ○ By Ambulance/EMS

9. All medications you are currently taking?
- ○ *Not taking medication*
- ○ Anti-inflammatory (Aspirin, Motrin, etc.)
- ○ Muscle Relaxants
- ○ Pain Medication/Analgesic
- ○ Birth Control Pills
- ○ Other _____
- ○ Other _____
- ○ Other _____

10. List all surgical operations and years:
- ○ *No surgical history*

_____ year
_____ year
_____ year
_____ year
_____ year

11. What are your habits?

	None	Occasionally	Moderately	Excessively
Smoking	○	○	○	○
Alcohol	○	○	○	○
Exercise	○	○	○	○

12. Which of the following illnesses/conditions have you had?
- ○ *No previous illnesses or conditions*
- ○ Yes (Please list)
  - ○ Diabetes
  - ○ Cancer
  - ○ Epilepsy
  - ○ Thyroid Condition
  - ○ High Blood Pressure
  - ○ Stroke
  - ○ Ulcer
  - ○ Asthma
  - ○ HIV/AIDS
  - ○ Multiple Sclerosis
  - ○ Scoliosis
  - ○ Arthritis
  - ○ Depression
  - ○ Rheumatic Fever
  - ○ Disk Injury
- ○ Other (Please list) _____

PAYMENT FOR PROFESSIONAL SERVICES

Physician
Chris Johnson, D.C.

Would you like our office to file insurance claims for you? ❑ Yes ❑ No

Method of payment for today's charges? ❑ Cash ❑ Check ❑ Visa, MasterCard, Am. Express, Discover

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare and file insurance claim forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date _____

Guardian Signature Authorizing Treatment: _____ Date _____

Guardians relationship to patient: _____

WORK ACCIDENT/INJURY PATIENTS COMPLETE THIS SECTION

Date of accident/injury _____/ _____ / _____

Give details of how the accident or injury occurred: _____

Was your employer/supervisor notified of your injury?

❑ *No* ❑ *Yes⇒* *Name of person notified:* _____

Did your employer/supervisor instruct you to see a specific doctor or health care facility?

❑ *No* ❑ *Yes⇒* *If Yes, Who?* _____

Notice: If you were injured on the job you must report the injury to your employer. To receive treatment under worker's compensation you must return completed the **TREATMENT AUTHORIZATION FORM** next office visit.

PLEASE DO NOT WRITE BELOW THIS LINE

This injury was verified by: _____ On (Date) _____ Time _____ a.m. p.m.

Name of supervisor who verified injury: _____

Notes: _____

AUTO ACCIDENT PATIENTS COMPLETE THIS SECTION

Physician
Chris Johnson, D.C.

Date of Accident ___ /___ /___

What was your location in the vehicle?
❑ *Driver* ❑ *Passenger front* ❑ *Passenger left rear* ❑ *Passenger right rear*

Total number of vehicles involved in accident?
❑ *One* ❑ *Two* ❑ *Three* ❑ *Other*

What damage did your vehicle sustain?
❑ *Minimal* ❑ *Moderate* ❑ *Severe* ❑ *Unsure*

Immediately after the accident, you were:
❑ *Unconscious* ❑ *Confused* ❑ *Weak* ❑ *Nervous* ❑ *Dizzy* ❑ *Dazed* ❑ *Other*

Road conditions at the time of the accident:
❑ *Wet* ❑ *Dry* ❑ *Icy*

Were you aware of the approaching accident or did it catch you by surprise?
❑ *Caught by surprise* ❑ *Aware*

Choose all that apply to you at the time of the accident:
Were you wearing your seatbelt? ❑ *Yes* ❑ *No*
Were you wearing your shoulder belt? ❑ *Yes* ❑ *No*
Did your airbag discharge? ❑ *Yes* ❑ *No* ❑ *N/A*

Did any part of your body strike any interior part of your vehicle?
❑ *No*
❑ *Can't recall*
❑ *Yes* ⇨

Head hit _____ Left hip hit _____
Chest hit _____ Right hip hit _____
Left shoulder hit _____ Left knee hit _____
Right shoulder hit _____ Right knee hit _____
Other _____

Patient Signature _____ **Today's Date** _____

END OF PATIENT INFORMATION - RETURN FORM TO FRONT DESK. THANK YOU!