

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

Please complete this questionnaire. This confidential history will be part of your permanent records.

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

Your Name _____ **Date** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____

Age _____ **Date of Birth** _____ **SS#** _____

Gender (check one) Male Female Unspecified

E-mail _____ **Marital Status** M S D W

Preferred Contact Method: Home Phone Cell Phone Work Phone Email

Preferred Language: (check one)

<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Chinese	<input type="checkbox"/> French	<input type="checkbox"/> German
<input type="checkbox"/> Tagalog	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Italian	<input type="checkbox"/> Korean	<input type="checkbox"/> Russian	<input type="checkbox"/> Polish
<input type="checkbox"/> Arabic	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Japanese	<input type="checkbox"/> French Creole	<input type="checkbox"/> Greek	<input type="checkbox"/> Hindi
<input type="checkbox"/> Persian	<input type="checkbox"/> Urdu	<input type="checkbox"/> Gujarati	<input type="checkbox"/> Armenian	<input type="checkbox"/> I choose not to specify	

Race (check one)

<input type="checkbox"/> White	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> American Indian/Alaskan Native
<input type="checkbox"/> Asian	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Filipino
<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Native Hawaiian or other Pacific Island
<input type="checkbox"/> Samoan	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Other _____	<input type="checkbox"/> I choose not to specify

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Employment Status (Check one)

Employed FT Student PT Student Other Retired Self Employed

Your Occupation _____ **Employed by** _____

Phone # _____ **Address** _____

Is your visit due to an accident? Yes / No

Are you a 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 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 _____

Primary Care Physician _____

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:** _____

Verification Question (Choose only one question by checking the question, then give the answer to that question)

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
 What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
 What was the make of your first car? When is your anniversary? What is your favorite color?

Verification Answer to the Chose question: _____

Do you currently smoke tobacco of any kind? Yes Former smoker never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

- 0 1 2 3 4 5 6 7 8 9 10
No interest *Very interested*

Present Complaints (please circle the appropriate ones)

- | | | | |
|------------------|--------------------------|----------------------|--------------------------|
| 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 hand |
| 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 radiating 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?

Is this conditions interfering with your: Work Sleep Daily Routine Other _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? Yes No

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: Improved Unchanged Getting Worse

List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____

2. _____ Specialty _____

What do you think caused this condition? _____

Patient Name _____ Date _____

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

List any operations that you've had and approximate dates:

1. _____ Date: _____ Dr. _____
2. _____ Date: _____ Dr. _____
3. _____ Date: _____ Dr. _____
4. _____ Date: _____ Dr. _____
5. _____ Date: _____ Dr. _____

Are you allergic to any medication? Please list: _____

Are you taking any medications? Please list: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c >9.0% Yes No Not sure
If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low-back spine in the past 28 days? Yes No

Do you wear Orthotics (shoe inserts)? Yes No

If yes, what type? _____

Are you pregnant? Yes No **Due Date:** _____

Do you: **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

Patient Name: _____ **Date:** _____

Insurance Coverage Information

Medical Insurance:

Insurance Carrier: _____ Phone: _____
Policy Holder Name: _____ Policy Number: _____
Group Number: _____

Worker's 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: _____ Phone: _____
THEIR Insurance Carrier: _____ Phone: _____
Address: _____
Adjuster: _____ Claim Number: _____

Patient Name: _____ Date: _____

To be performed by clinic staff:

Height: _____ inches **Weight:** _____ pounds **BP:** _____ / _____ **Pulse** _____