

# CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

CASE ID :

PATIENT NAME :

REFERRED BY

1. LAST NAME :

2. FIRST NAME :

3. MI :

4. TITLE :

5. ADDRESS :

6. CITY :

7. STATE :

8. ZIP :

9. HOME PHONE #:

10. CELL PHONE :

11. D.O.B :

12. AGE :

13. SEX :      M      F

14. SOC.SEC.# :

15. MARITAL STATUS :      S      M      D      W

16. SPOUSE'S NAME :

17. SPOUSE'S SOC.SEC. #:

18. WHO IS RESPONSIBLE FOR YOUR BILL:      SELF      AUTO INS.      WORKER'S COMP      PERSONAL HEALTH INS      MEDICARE

19. OTHER :

## EMPLOYER INFORMATION

1. OCCUPATION :

2. EMPLOYER :

3. ADDRESS :

4. CITY :

5. STATE :

6. ZIP :

7. BUSINESS PHONE #:

8. FAX # :

## INJURY INFORMATION

1. INSURANCE TYPE : PRIVATE      AUTO      WORK      SLIP & FALL  
2. PATIENT'S RELATIONSHIP TO INSURED      SELF      SPOUSE      CHILD      DRIVER  
3. DATE OF INJURY :

4. IF AUTO INJURY WHERE YOU?      DRIVER      PASSANGER      PEDESTRIAN

5. POLICY # :

6. CLAIM # :

7. WORKER'S COMP # :

8. DESCRIBE HOW INJURY HAPPENED?

9. DID YOU REPORT INJURY?      YES      NO      TO WHOM ?

10. WERE YOU HOSPITALIZED?      YES      NO      WHERE ?

11. X- RAYS TAKEN?      YES      NO      BY WHOM ?

12. WERE YOU WORKING AT THE TIME OF THE ACCIDENT?      Yes      No

13. DATES LOST FROM WORK :

14. NAME OF OTHER DOCTORS SEEN FRO THIS INJURY?

15. NAME OF ATTORNEY :      16. ATTORNEY'S PHONE # :

## INSURANCE INFORMATION

1. INSURED'S NAME :

2. PATIENT'S RELATIONSHIP TO INSURED      SELF      SPOUSE      CHILD

3. NAME OF INSURANCE CO. :

4. ADDRESS :

5. INSURANCE PHONE # :      6. POLICY # :

### **SECONDARY INSURANCE**

7. NAME OF INSURANCE CO. :

8. ADDRESS :

9. INSURANCE PHONE # :      10. POLICY # :

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1. MAJOR COMPLAINTS('S) :

2. CHECK YOUR PRESENT AND PAST SYMPTOMS :

PRESENT	PAST	PRESENT	PAST
	NECK PAIN		EXCESSIVE THIRST
	MIDDLE BACK PAIN		CHRONIC COUGH
	LOW BACK PAIN		CHRONIC SINUSITIS
	HEADACHE		GENERAL FATIGUE
	DIZZINESS		PAINFUL URINATION
	CONVULSIONS		FREQUENT URINATION
	FAINTING, VISUAL		ABDOMINAL PAIN
	DISTURBANCE, NAUSEA		DIFFICULTY IN SWALLOWING
	SHOULDER PAIN		DEPRESSION
	PAIN IN UPPER ARMS OR ELBOWS		HIGH BLOOD PRESSURE
	PAIN IN UPPER LEG OR HIP		ANGINA
	PAIN IN LOWER LEG OR KNEE		HEART ATTACK
	PAIN IN ANKLE OR FOOT		STROKE
	SWELLING/STIFFNESS OF JOINTS		ASTHMA
	MUSCULAR INCOORDINATION		CANCER
	JAW PAIN		EMPHYSEMA (LUNG DISORDERS)
	TINNITUS (EAR NOISES)		ARTHRITIS
	CHEST PAIN		DIABETES
	RAPID HEART BEAT		ULCER
	LOSS OF APPETITE		BLADDER INFECTION
	BLOOD DISORDER		COLITIS

3. Please describe the character of your current pain:

Weakness	Throbbing/Gnawing	Numbness	Shooting	Sharp/Dull	Aches	Dull	Soreness

4. Did your problem begin: Due to an accident      Multiple incidents      Gradually No Specific Reason  
other

5. Describe how your problem began:

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6. What treatments have you're received for this present condition?	Surgery	Spinal Injections	Physical Therapy		
Chiropractic	Medicine	X-Ray Acupuncture	Other		
7. Have your been treated previously for the same condition?	Yes	No			
If yes, by:	MD	Chiropractor	Physical Therapist	Other	
8. What makes your problem better?	Nothing	Lying Down	Walking	Standing	Sitting
Movement/Exercise	Inactivity	Other			
9. What makes your problem worse?	Nothing	Lying Down	Walking	Standing	Sitting
Movement/Exercise	Inactivity	Other			
10. Do you work?	Yes	No	If yes:	Sitting more than 50% of workday	Light Manual labor
Manual Labor	Heavy Manual Labor	Other			
11. Are your complaints affecting your ability to work or otherwise be active?					
No effect	some physical restrictions (able to perform light duty housework and household tasks)				
need limited assistance with everyday tasks.					Need assistance often
have a significant inability to function without assistance?					Cannot care for self.
12. Are you currently taking medication?	Yes	No			
If yes:					
13. Are you allergic to any drugs or medication?	Yes	No			
If yes:					
14. Do you smoke?	Yes	No	How many packs/Day?		
15. Do you suffer from any type of allergies?	Yes	No			
If yes:					
16. Have you had any surgery?	Yes	No			
If yes:					
17. Women: Are you pregnant?	Yes	No	Not sure	Patient's Initials	
<b>FAMILY HISTORY</b>					
	DIABETES	HEART	KIDNEY	CANCER	BACK OTHER CONDITION
MOTHER					
FATHER					
BROTHER(S)					
SISTER(S)					

**I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.**