



# Confidential History

# Questionnaire

Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

Gender: M F Marital Status: M S D W Ages of children: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone:( ) \_\_\_\_\_ Work Phone:( ) \_\_\_\_\_ Cell Phone:( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse's First Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Why did you choose our office? \_\_\_\_\_

### REASON FOR CONSULTING OUR OFFICE...

Please check one of the following:

**I have no specific problem.** I understand the role of chiropractic in my general health care.

**I am experiencing a symptom** of a potential underlying problem and I want to find out if chiropractic care will help my body to work better and have a greater potential to heal itself.

*If you have a specific issue for today's consultation, please briefly describe it, including its effect on your daily life.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Is this problem a result of an injury? NO YES: ( \_\_\_ auto \_\_\_ work \_\_\_ other)*

List all other **health concerns** you may have:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all **medications** you are taking (including over the counter):

\_\_\_\_\_  
\_\_\_\_\_

List any **surgeries**: \_\_\_\_\_

Approximate date of most recent **spine x-rays**: \_\_\_/\_\_\_/20\_\_\_ Other imaging: \_\_\_\_\_

Previous chiropractor's name: Dr. \_\_\_\_\_ Date of last visit: \_\_\_/\_\_\_/\_\_\_

Approximate length of care: \_\_\_\_\_ Reason for discontinuing: \_\_\_\_\_

Do you have health insurance? NO YES: ( \_\_\_ BCBS \_\_\_ Medicare \_\_\_ Other)

Research has shown that many of our current health challenges have their origins from previous trauma...

**Have you been in any motor vehicle accidents greater than 3 mph?**

Date of most recent: \_\_\_/\_\_\_/\_\_\_ Approx. Speed: \_\_\_mph Injuries: \_\_\_\_\_

Date of next recent: \_\_\_/\_\_\_/\_\_\_ Approx. Speed: \_\_\_mph Injuries: \_\_\_\_\_

Date of next recent: \_\_\_/\_\_\_/\_\_\_ Approx. Speed: \_\_\_mph Injuries: \_\_\_\_\_

**Do/did you have stress or strain related to work?** no yes \_\_\_\_\_

Date of most recent: \_\_\_/\_\_\_/\_\_\_

**Do/did you suffer from emotional traumas?** no yes \_\_\_\_\_

Date of most recent: \_\_\_/\_\_\_/\_\_\_

**Do/did you play adult sports?** no yes \_\_\_\_\_

Date of most recent stress/strain: \_\_\_/\_\_\_/\_\_\_

**Other traumas from childhood or elsewhere:** \_\_\_\_\_

**How have you been eating?:**



- \_\_\_ sugar-free/diet foods
- \_\_\_ dairy products
- \_\_\_ artificial sweeteners
- \_\_\_ microwaved foods
- \_\_\_ hydrogenated oils (trans-fats)
- \_\_\_ organic foods regularly
- \_\_\_ omega-3 fatty acids (DHA/EPA)
- \_\_\_ probiotics
- \_\_\_ 5-9 servings of fruits & veggies/day
- \_\_\_ 100% whole food multi-vitamin

**How have you been moving?:**



- \_\_\_ I regularly do cardiovascular exercise.. 7 6 5 4 3 2 1 0 days per week
- \_\_\_ I regularly do strength exercise..... 7 6 5 4 3 2 1 0 days per week
- \_\_\_ I regularly do flexibility exercise..... 7 6 5 4 3 2 1 0 days per week
- \_\_\_ I regularly do core muscle exercise..... 7 6 5 4 3 2 1 0 days per week

**How have you been thinking?:**



- \_\_\_ I often feel anxious/nervous
- \_\_\_ I often feel depressed
- \_\_\_ I often feel angry/upset
- \_\_\_ I often feel worried
- \_\_\_ I often feel unhappy
- \_\_\_ I consider my job stressful
- \_\_\_ I regularly feel calm
- \_\_\_ I regularly feel optimism
- \_\_\_ I regularly feel peaceful
- \_\_\_ I regularly don't worry
- \_\_\_ I regularly feel happy
- \_\_\_ I don't consider my job stressful

**How would you rate your overall stress level? (low) 1 2 3 4 5 6 7 8 9 10 (high)**

**Females only:**

I am extremely confident that I am not pregnant at the current time due to: abstinence, birth control medication, hysterectomy, menopause, vasectomy (spouse), tubal ligation, or because I am in the first 14 days of my current menstrual cycle. I consent to use of x-ray if the doctor requires such examination in my case.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/20\_\_\_

**PAYMENT ACKNOWLEDGEMENT**

I understand that my health insurance policy is an arrangement between me and my insurance carrier. I also understand that this chiropractic office will furnish documentation to assist me in making collection from my insurance company. Any and all fees will be discussed with me in advance. I further understand and agree that I am responsible for all charges from all services rendered to me. I have read and understand the preceding paragraph and I have completed this form with accurate information regarding my health. I also give my consent for this office to examine me and use x-ray if necessary.

Signature (parent/guardian required for minors): \_\_\_\_\_ Date: \_\_\_/\_\_\_/20\_\_\_