HEALTH QUESTIONNAIRE

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

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** this form.

Patient Name:

MO	DAY	YEAR
① ⑦	①	⓪
② ⑧	② ⑩	①
③ ⑨	③ ⑳	②
④ ⑩	④ ㉚	③
⑤ ⑪	⑤ ㊵	④
⑥ ⑫	⑥ ㊿	⑤
	⑩ ⑦	⑥
	⑳ ⑧	⑦
	㉚ ⑨	⑧
		⑨

DR# PATIENT NUMBER

Date Of Birth

Email

Patient's Home Address

Phone Cell

Employer Business Address

Phone

Occupation

Referred By

Spouse Name

Sex:
- ○ Male
- ○ Female

Marital Status:
- ○ Single
- ○ Married
- ○ Widowed
- ○ Divorced
- ○ Other

Patient Resides With:
- ○ Lives Alone ○ Spouse ○ Parents
- ○ Children ○ Other

Children: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

A. MAJOR COMPLAINTS

1. What are your major complaints?

○ None	Pain	Numbness	Tingling
Head	Ⓗ	Ⓗ	Ⓗ
Neck	Ⓝ	Ⓝ	Ⓝ
Upper Back	Ⓤ	Ⓤ	Ⓤ
Mid Back	Ⓜ	Ⓜ	Ⓜ
Lower Back	Ⓛ	Ⓛ	Ⓛ

	R	L	R	L	R	L
Shoulder	Ⓢ	Ⓢ	Ⓢ	Ⓢ	Ⓢ	Ⓢ
Arm	Ⓐ	Ⓐ	Ⓐ	Ⓐ	Ⓐ	Ⓐ
Forearm	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ
Hand	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ
Buttock	Ⓑ	Ⓑ	Ⓑ	Ⓑ	Ⓑ	Ⓑ
Hip	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ
Thigh	Ⓣ	Ⓣ	Ⓣ	Ⓣ	Ⓣ	Ⓣ
Leg	Ⓛ	Ⓛ	Ⓛ	Ⓛ	Ⓛ	Ⓛ
Foot	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ

2. Currently your pain is aggravated by
- ○ Coughing
- ○ Sneezing
- ○ Straining At Stool
- ○ Neck Movement
- ○ Reaching
- ○ Other
- ○ Lifting
- ○ Bending
- ○ Sitting
- ○ Standing
- ○ Walking

3. Since your symptoms began, have you noticed a change in
- ○ Bowel Function
- ○ Bladder Function
- ○ Ability To Maintain An Erection

B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

1. a. GENERAL
- ○ Normal
- ○ Fatigue
- ○ Weakness
- ○ Fever
- ○ Chills
- ○ Weight Change
- ○ Night Sweats
- ○ Other

b. SKIN
- ○ Normal
- ○ Rash
- ○ Redness
- ○ Itching
- ○ Eczema
- ○ Hair Changes
- ○ Nail Changes
- ○ Other

c. NEUROLOGIC
- ○ Normal
- ○ Headache
- ○ Dizziness
- ○ Fainting
- ○ Convulsions
- ○ Other

d. EYES

○ Normal	Right	Left
Vision Trouble	○	○
Pain	○	○
Discharge	○	○
Other	○	○

e. EARS

○ Normal	Right	Left
Hearing Trouble	○	○
Ringing	○	○
Pain	○	○
Discharge	○	○
Other	○	○

f. NOSE
- ○ Normal
- ○ Pain
- ○ Bleeding
- ○ Absence Of Smell
- ○ Other

g. MOUTH/THROAT
- ○ Normal
- ○ Sores
- ○ Bleeding
- ○ Absence Of Taste
- ○ Abnormal Taste
- ○ Other

h. HEART/LUNGS
- ○ Normal
- ○ Cough
- ○ Wheezing
- ○ Difficulty Breathing
- ○ Swollen Extremities
- ○ Blue Extremities
- ○ Murmur
- ○ Chest Pain
- ○ Palpitations
- ○ Other

i. BREASTS
- ○ Normal
- ○ Lumps In Breast(s)
- ○ Redness/Itching
- ○ Pain
- ○ Dimpling
- ○ Discharge
- ○ Other

j. STOMACH/INTESTINES
- ○ Normal
- ○ Decreased Appetite
- ○ Increased Appetite
- ○ Abdominal Pain
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Other

k. REPRODUCTIVE/URINATION
- ○ Normal
- ○ Inability To Hold Urine
- ○ Painful Urination
- ○ Frequent Urination
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding
- ○ Impotence
- ○ Sterility
- ○ Other

l. GLANDULAR
- ○ Normal
- ○ Heat/Cold Intolerance
- ○ Sugar In Urine
- ○ Goiter
- ○ Tremor
- ○ Other

m. MENTAL
- ○ Normal
- ○ Anxiety
- ○ Depression
- ○ Memory Loss or Impairment
- ○ Phobias
- ○ Mood Swings
- ○ Other

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PLEASE MAKE NO MARKS IN THIS AREA

2. What are your habits?

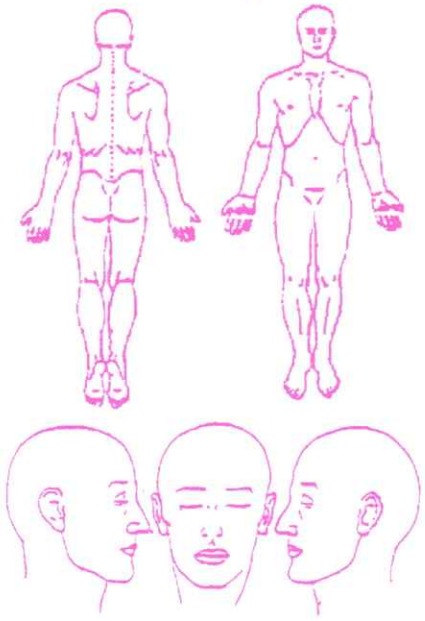
	Never	Occasionally	Moderately	Excessively
Smoking	(S)	(S)	(S)	(S)
Alcohol	(A)	(A)	(A)	(A)
Recreational Drugs	(R)	(R)	(R)	(R)
Exercise	(E)	(E)	(E)	(E)

3. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)
Mother	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)
Brothers	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)
Sisters	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)
Children	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)

C. PAIN DIAGRAMS

Please mark the location of your pain on these figures



D. MEDICAL HISTORY

1. HEALTH CARE

	Yes	No
a. Have you been to a chiropractor	(Y)	(N)
b. Do you have a family physician	(Y)	(N)
c. WOMEN:		
To the best of your knowledge are you pregnant	(Y)	(N)
Are you under the regular care of an OB-GYN	(Y)	(N)
d. Have you been hospitalized in the past five years	(Y)	(N)
e. Are you currently taking any medication	(Y)	(N)

- ◯ Anti-inflammatory (Aspirin, Motrin, etc.)
- ◯ Muscle Relaxants
- ◯ Pain Medication/Analgesic
- ◯ Tranquilizers
- ◯ Birth Control Pills
- ◯ Other

2. Which of the following illnesses have you had?

- ◯ *No Previous Conditions/Illnesses*
- ◯ Arthritis
- ◯ Asthma
- ◯ Sinus Trouble
- ◯ Hay Fever
- ◯ Allergies
- ◯ Tuberculosis
- ◯ Diabetes
- ◯ Epilepsy
- ◯ Thyroid Trouble
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Heart Trouble
- ◯ HIV/ARC
- ◯ AIDS
- ◯ Sexually Transmitted Disease
- ◯ Ulcer
- ◯ Cancer
- ◯ Polio
- ◯ Rheumatic Fever
- ◯ Serious Injury
- ◯ Bone Fracture
- ◯ Dislocated Joints
- ◯ Spinal Disc Disease
- ◯ Multiple Sclerosis
- ◯ Scoliosis
- ◯ Mental/Emotional Difficulty
- ◯ Prostate Trouble
- ◯ Kidney Trouble
- ◯ Other

E. INSURANCE INFORMATION

	Yes	No
1. Is your condition due to an automobile accident	(Y)	(N)
Date of Accident		
Have You filed an accident report	(Y)	(N)
2. Is your condition due to a job injury	(Y)	(N)
Date of Injury		
Have You filed an injury report	(Y)	(N)
3. Do you have health insurance	(Y)	(N)
Company		
Policy #		
4. Are you covered by Medicare	(Y)	(N)
Medicare #		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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.

F. PAYMENT

I WILL BE PAYING TODAY BY:

◯ Cash ◯ Check ◯ Credit Card

◯ MasterCard ◯ Visa ◯ American Express

Account # _____ Exp. Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Consent for Chiropractic Treatment and Acknowledgement of Receipt of Information

To the patient: Every type of health care is associated with some risks of a potential problem. Health care providers, including chiropractors, are required, by law to tell you the nature of your condition, the general nature of treatment, the risks involved, and the reasonable therapeutic alternatives.

You are being asked to sign a confirmation that we have discussed all your insurance matters with you as well as any copayments and deductibles due at the time of service. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities.

My Coverage is as follows:

_____

_____

_____

Consent

I hereby authorize and direct D.E. Greene Family Chiropractic, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, various modes of physical therapy, x-rays, and any additional procedures or services that may be deemed necessary and reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure, my current covered benefits and also non-covered benefits. That my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient's name_____Date_____Time_____

Signature of patient, parent, or guardian_____

Relationship to patient_____

I certify that I have provided and explained the information set forth herein, including any attachments, and have answered all questions concerning proposed treatment to the best of my knowledge and ability.

Signature of chiropractic physician_____Date_____Time_____

Privacy Consent

This form is optional under the new patient privacy regulations recently issued by the United State Department of Human Services. We have elected to use this form. Prior to commencing your chiropractic treatment, you should review, sign and date this form.

Your protected health information (i.e., individual identifiable information such as names, dates, phone/fax numbers, email address, social security numbers, and demographic data) may be shared in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure). In the course of providing care, providers will share either written or electronic patient information with other providers who are involved in the patient's care, as appropriate.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that an action has been taken in reliance on this consent.

Thank You for your cooperation. Please let us know if you have any questions.

Please list any additional people whom we may share the patient's treatment, scheduling and financial information with. Due to the standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") any person not specifically named on this form will NOT be able to obtain any information.

Name:	Relationship to the patient:
_____	_____
_____	_____
_____	_____
Print Patient Name	Date
_____	_____
Patient's Signature (If 18yrs or older)	Parent or Legal Guardian Signature

D.E. Greene Family Chiropractic
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