Chiropractic Patient Questionnaire

Patient Data

First Name ________________________ Last Name ________________________ Date __________ Email* ________________________

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing Address

Address __________________________________ City ________________________ State __________________ Zip ______________________

Phone: Work ________________ Home _________________ Mobile _____________ Referred by ____________________________________

Age: _________ Date of Birth ___________________ Social Security No. __________________________ No. of Children ______________

Occupation ____ Employer ____

Marital Status ____________ Spouse's Name ____________________ Spouse's Occupation ___________________________________

Emergency Contact ____ Phone _____________

Current Complaints

Nature of Injury/condition; ☐ Motor Vehicle Accident ☐Work Injury ☐ other

Please Describe ____

Date of Injury _________________________ Date Symptoms Appeared ________________________________

Have you had this condition before? ☐ No ☐Yes If yes, when? ____________________________________

Have you had previous chiropractic care? ☐ No ☐ Yes

If yes, describe. ____

Insurance Information

Name of Party Responsible for Payment _____________________________________ Phone ______________________________________

Do you have health insurance? ☐ No ☐ Yes Name of Company/Group # ____

If an auto accident, please provide:

Insurance Company name ____________________________________ Contact Person ____

Phone ____ Claim Number ____

Assignment and Release/Authorization for Treatment

I, the undersigned certify that I (or my dependent) have (health or accident) insurance coverage with __________________________________ and assign directly to Dr. Haneline all insurance benefits, if any, otherwise payable to me for services rendered. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. Any charges that are not covered by insurance will be immediately due and payable. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Also, I, the undersigned patient, hereby authorize Dr. Haneline (either the doctor or qualified staff) to administer such treatment as necessary. I hereby certify that I fully understand that I am giving authorization for chiropractic treatment. I also certify that no guarantees or assurances have been made as to the results that may be obtained within.

Patient/Guardian/Responsible Party's Signature ____ Date __________________________

Patient/Guardian/Responsible Party's Name ____Date __________________________

(Please print name here.)

PLEASE TURN PAGE OVER

Medical History—Please be concise but accurate with your information.

Have you been treated for any conditions in the past year? ☐ No ☐ Yes If yes please describe.

____

Date of last physical exam? ______________________ For females: Is there a chance you are pregnant? ☐ No ☐ Yes

Have you had x-rays taken? ☐ No ☐ Yes, If Yes, where? ____

Please list any current medications along with the condition(s). ______________________________________

____

Please list any vitamins, herbs, etc. you are taking. ____

____

Have you ever:	No	Yes	Briefly Explain
Broken Bones?	☐	☐	
Been hospitalized?	☐	☐	
Had sprain/strains?	☐	☐	
Been struck unconscious?	☐	☐	
Had surgery?	☐	☐	

Family History

Present and Past Significant Health Conditions (Parents/Siblings/Children--examples: heart disease, cancer, arthritis, etc.)

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	No	Yes
Do you experience pain every day?	☐	☐
Do your symptoms interfere with your daily life?	☐	☐
Does your pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms? ____

____

Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Do you sleep well? ☐ Yes ☐ No ____

Is your appetite good? ☐ Yes ☐ No ____

Do you get regular exercise? ☐ No ☐ Yes If yes, briefly describe ______________________________

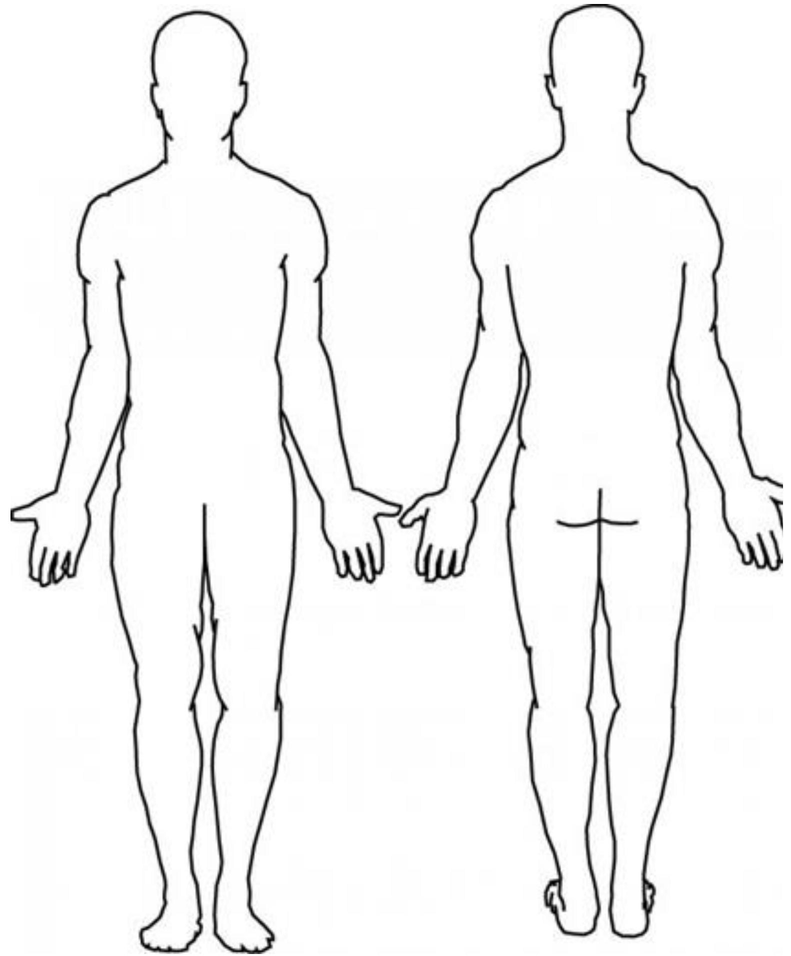
CHECK ANY BELOW, CURRENT AND/OR PAST

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Frequent Urination
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps in Breast
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Prostate Trouble
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other:

THIS SIDE FOR DOCTOR'S USE—DO NOT FILL IN.

A=Ache B=Burning P=Pins & Needles

N=Numbness S=Stabbing O=Other



Notes:

Discussion:____

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Chief Complaint:______________________DO/DA__________

Relieved by: ____

Worsened by: ____

Self Tx: ____

Procured Tx: ____

Secondary Complaint: ______________________________________

____

Tertiary Complaint: ______________________________________

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Discussion: ____

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