Submit Print

Health Questionnaire

Patient Information

Patient Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

List all prescription/non-prescription/other supplements that you take as well as associated conditions:

_____

_____

_____

List any surgeries or hospitalizations you have had. Please include the month/year for each:

_____

_____

_____

List anything you are allergic to:

_____

Family History – list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you or the individual:

_____

_____

_____

Do you exercise? ☐Yes ■No

If "Yes" to exercise: How many hours per week? _____

If "Yes" to exercise: What activities? _____

Do you smoke? ☐ Yes ▣No

If "Yes" to smoking: How many cigarettes per day? _____

If "Yes" to smoking: How many years? _____

Do you drink alcoholic beverages? ■Yes ☐No

If "Yes" to alcoholic beverages: How many drinks per day? _____

Do you wear: ☐Heal lifts ☐Arch Supports ☐Prescription Orthotics

For women: Are you: ☐Pregnant or nursing?

If pregnant, how many weeks? _____

Date of last menstrual period: _____

Medical History:

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

When did your symptom start? _____

How did your symptoms begin?

_____

How often do you experience symptoms? Constantly Frequently Occasionally Intermittently

Describe your symptoms (check all that apply):

☐Sharp ☐Dull ache ☐Numbing ☐Burning ☐Tingling ☐Shooting

Are your symptoms (check one) ☐Getting better ☐Same ☐Getting worse

How do your symptoms interfere with your work or normal activities?

_____

_____

_____

Have you experiences these symptoms in the past? ☐Yes ☐No

If "yes" to experiencing in the past: When? _____

Are you here because of an accident? ☐Yes ☐No

If "yes" to accident what type was it? _____

History of Treatment

Primary care physician name: _____

Phone # of PCP: _____ Date last seen: _____

May we update your PCP on your condition?

Have you seen a chiropractor before? ☐Yes ☐No

Who referred you to us? _____

Have you seen another doctor for these symptoms? ☐Yes ☐No

If "yes" to seeing another doc for these symptoms, please indication name and type of medical provider:

Name: _____

Provider type: _____

Financial Policy

Insurance Coverage

Welcome to our office. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment on your account. Please notify this office if the status of your insurance changes.

Private Pay (please initial):
_____As I have no insurance, I agree to assume all responsibility and try to keep my account current by paying for services when they are rendered.

_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance (please initial):
_____I would like this clinic to bill my insurance. I understand that I am responsible for the costs of treatment.

Missed Appointments

It is the policy of this office to asses a $40.00 missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessments of a fee, but you will be charged for any additional missed visits. The clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ My initial here indicate that I understand the above missed visit policy.

I understand that all heal services rendered to me and charged to me are my personal financial responsibility. I under sand and agree to the conditions of this policy.

_____ _____
Signature Date

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