PATIENT QUESTIONAIRE

NAME: ____ BIRTHDATE: ___________________

ADDRESS ____
STREET / P.O. BOX CITY STATE ZIP

HOME PHONE: ________________________ MOBILE PHONE: ________________________

EMPLOYER: _____________________ WORK PHONE: ______________________________

MARITAL STATUS □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED

EMAIL: ______________________ PATIENT LOGIN (WELCOME/ACTIVATION CODE SENT) □NO □YES

NEXT OF KIN: ____________________ RELATIONSHIP: ______________ PHONE: ___________

EMERGENCY CONTACT: ________________ RELATIONSHIP: _________ PHONE: ___________

DID ANYONE REFER YOU TO OUR OFFICE? □NO □YES- WHO: ___________________

RACE:______________ ETHNICITY: □ HISPANIC □ NOT HISPANIC LANGUAGE: ______________

PCP: _________________________ SPECIALTY: ______________ PHONE: ______________

ADDRESS: ____

CAN WE SHARE DATA WITH YOUR PCP? □NO □YES

HISTORY OF PRESENTING ILLNESS / INJURY

WHAT ARE YOUR SYMPTOMS? ____

DATE SYMPTOMS BEGAN? ____

HOW DID IT OCCUR? _________________ □WORK RELATED □AUTO ACCIDENT

HAVE YOU MISSED ANY WORK? □NO □YES

DO YOU HAVE ANY RECENT X-RAY OF THAT AREA(S)? □NO □YES-FACILITY WHERE TAKEN? ___________

PAST MEDICAL HISTORY

HAVE YOU RECEIVED CARE FROM A CHIROPRACTOR BEFORE? □NO □YES- WHO: ________________

INSURANCE COVERAGE □NO □YES

Primary Insurance

Insurance Co_______________________________

Policy/Subscriber ID#________________________

Group #___________________________________

Policyholder Name___________________________

Policyholder Relationship to You________________

Policyholder DOB ___________________________

Policyholder Employer _______________________

Secondary Insurance

Insurance Co_______________________________

Policy/Subscriber ID#________________________

Group #___________________________________

Policyholder Name___________________________

Policyholder Relationship to You________________

Policyholder DOB ___________________________

Policyholder Employer _______________________