Pulliam Chiropractic Clinic, LLC
P.O. Box 6776
Slidell, Louisiana 70469
(985) 649-0023
Mandeville: (985) 727-2255 Fax: (985) 661-9933

PRELIMINSARY INFORMATION QUESTIONNAIRE

PATIENT INFORMATION: Minor Single Married Divorced Widowed Sex: M F

Last Name:_____First:_____M.I._____

Social Security #_____/_____/_____Date of Birth:_____/_____/_____Age:_____

Address:_____City:_____State:_____Zip:_____

Home#_____ Cell#_____

Place of Employment:_____Phone#_____

Employer's Address:_____

INSURANCE POLICY HOLDER (If different from Patient)

Last Name:_____First:_____M.I:_____ Sex: M F

Date of Birth:_____/_____/_____Home#_____Cell#_____

Address:_____City:_____State:_____Zip:_____

SPOUSE INFORMATION (If different from above)

Last Name:_____First:_____M.I._____ Sex: M F

Social Security#_____/_____/_____ Date of Birth:_____/_____/_____

GENERAL INFORMATION

Incase of Emergency Notify:_____Phone:_____Relationship:_____

What other health care have you received for this problem?_____

Is this injury due to an accident: Yes No, Auto Work Other

Date Accident or Illness begin:_____.City and State accident happened in:_____

INSURANCE INFORMATION (If you don't have you card)

Who referred you to our office?(Doctor/Friend/Phonebook)_____Phone:_____

Primary Insurance Plan:_____Policy Holder's Name:_____

ID#_____Group#_____Phone_____

Patient(or Parent/Guardian)_____.Today's Date_____
Signature

DO YOU HAVE, OR HAVE EVER HAD, PROBLEMS WITH THE FOLLOWING?

PLEASE CIRCLE

HEADACHES	YES	NO	NOW	PREVIOUS
DIZZINESS	YES	NO	NOW	PREVIOUS
BLURRED VISION	YES	NO	NOW	PREVIOUS
DEPRESSION	YES	NO	NOW	PREVIOUS
NERVOUSNESS	YES	NO	NOW	PREVIOUS
DIFFICULT SLEEP	YES	NO	NOW	PREVIOUS
LOSS OF ENERGY	YES	NO	NOW	PREVIOUS
TIRED IN THE MORNING	YES	NO	NOW	PREVIOUS
BUZZ/RINGING IN EARS	YES	NO	NOW	PREVIOUS
RUN DOWN	YES	NO	NOW	PREVIOUS
FAINTING	YES	NO	NOW	PREVIOUS
PALPITATION	YES	NO	NOW	PREVIOUS

GENERAL PROBLEMS WITH THE FOLLOWING:

HEAD	YES	NO	NOW	PREVIOUS
SINUSES	YES	NO	NOW	PREVIOUS
NECK PAIN/STIFFNESS	YES	NO	NOW	PREVIOUS
SHOULDER PAIN	YES	NO	NOW	PREVIOUS
UPPER BACK	YES	NO	NOW	PREVIOUS
MID BACK	YES	NO	NOW	PREVIOUS
CHEST PAIN	YES	NO	NOW	PREVIOUS
LUNG	YES	NO	NOW	PREVIOUS
HEART	YES	NO	NOW	PREVIOUS
BLOOD PRESSURE	YES	NO	NOW	PREVIOUS
STOMACH	YES	NO	NOW	PREVIOUS
INDIGESTION	YES	NO	NOW	PREVIOUS
BLADDER	YES	NO	NOW	PREVIOUS
KIDNEY	YES	NO	NOW	PREVIOUS
LIVER	YES	NO	NOW	PREVIOUS
COLON	YES	NO	NOW	PREVIOUS
CONSTIPATION	YES	NO	NOW	PREVIOUS
LOW BACK	YES	NO	NOW	PREVIOUS
HIP	YES	NO	NOW	PREVIOUS
LEG PAIN/CRAMPS	YES	NO	NOW	PREVIOUS
POOR CIRCULATION	YES	NO	NOW	PREVIOUS
HIV POSITIVE	YES	NO		

ANY PREVIOUS INJURIES

HOSPITAL/SURGERY YES NO BREAST IMPLANTS YES NO

DESCRIBE CIRCUMSTANCES _____

ARE YOU PREGNANT? _____ NUMBER & AGES OF CHILDREN: _____

ACCIDENTS (FALLS, AUTO, JOB) YES NO

DESCRIBE CIRCUMSTANCES _____

PLEASE LIST ALL MEDICATION YOU ARE TAKING _____

_____

ANY BLOOD RELATIVES WITH BACK PROBLEMS YES NO WHO _____

PATIENT'S SIGNATURE: _____ TODAY'S DATE: _____