

**GOODE INTEGRATIVE HEALTH CARE**  
**CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE**

This information is needed so we can better serve you. Please fill in ALL portions of the form.  
If you need assistance, please ask our receptionist, and we will be happy to help you.

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: M S D W Drivers License#/St \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Is your visit due to an accident? Yes No

Are you a Medicare patient? Yes No Are you a Medicaid patient? Yes No

Name of person to contact in case of emergency: \_\_\_\_\_

Their home and work phone number: \_\_\_\_\_

Who referred you to our office so we may thank them? \_\_\_\_\_

Primary Care and/or Referring Physician: \_\_\_\_\_

Medical Insurance Carrier Name: \_\_\_\_\_

Are you the policy holder? Yes No If not please fill out the following information.

Policy holder name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

## Present Complaints (please circle the appropriate ones)

Headache	Feet/hands cold	Head seems heavy	Pins and needles in arms R/L
Mental dullness	Depression	Confusion	Pins and needles in hand R/L
Loss of memory	Rib pain	Unbalanced	Pins and needles in legs R/L
Fainting	Neck stiffness	Constipation	Midback stiffness
Upper back pain	Lower back pain	Neck restriction	Nervousness
Shortness of breath	Fear	Upper back stiffness	Lower back stiffness
Eye strain/pain	Midback pain	Blurred vision	Double vision
Loss of smell	Irritability	Tension	Shoulder Pain

Difficulty in: Standing Sitting Bending Walking

Pain radiation to the: Right Arm Left Arm Right Leg Left Leg

Cannot Lift: Light Moderate Heavy Repetitive

Pain radiating to: Neck Base of skull Ribs Shoulders Arms

Pain in the: Foot Ankle Knee Hip Heel spurs

Other: \_\_\_\_\_

Since the time this(these) complaint(s) began, what, if anything have you tried that **did not** work? \_\_\_\_\_

Has the problem interrupted your sleep? Yes No How: \_\_\_\_\_

Does anyone in your family have the same or similar condition: Yes No  
Who: \_\_\_\_\_

List any doctors or therapists that you have seen for this complaint:

1. \_\_\_\_\_ Specialty \_\_\_\_\_  
2. \_\_\_\_\_ Specialty \_\_\_\_\_  
3. \_\_\_\_\_ Specialty \_\_\_\_\_

List any operations that you've had and approximate dates:

1. \_\_\_\_\_ Date \_\_\_\_\_  
2. \_\_\_\_\_ Date \_\_\_\_\_  
3. \_\_\_\_\_ Date \_\_\_\_\_  
4. \_\_\_\_\_ Date \_\_\_\_\_

Have you ever been involved in a motor vehicle accident? Yes No

If yes please list year(s): \_\_\_\_\_

Are you taking any medications? Yes No

Are you pregnant? Yes No Due Date: \_\_\_\_\_

Do you:      Smoke Yes No      Amount per day: \_\_\_\_\_  
                Drink Yes No      Light Medium Heavy  
                Exercise Yes No      Sometimes Frequently Regularly

**Relevant Medical History** (please circle the conditions you have or had previously)

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasms
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Polio
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	TB
Dizziness	Multiple Sclerosis	Venereal Disease

I attest that the above information is true and correct to the best of my knowledge. I further understand that any and all charges incurred by me in this office are **my sole responsibility**, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_