

ANDERSON CHIROPRACTIC 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	

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
Drink Yes No
Exercise Yes No

Amount per day: _____
Light Medium Heavy
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: _____