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/needles in arms R/L
Mental dullness	Depression	Confusion	Pins/needles in hand R/L
Loss of memory	Rib pain	Unbalanced	Pins/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:_____