

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

REFERRED BY: _____ E-MAIL ADDRESS _____

1. LAST NAME _____ 2. FIRST NAME _____ 3. MI _____

4. ADDRESS _____

5. CITY _____ 6. STATE _____ 7. ZIP _____

8. HOME # (____) _____ 9. WORK # (____) _____ 10. CELL # (____) _____

11. AGE ____ 12. DATE OF BIRTH ____ / ____ / ____ 13. SEX M F 14. SOC. SEC. # ____ - ____ - ____

15. MARITAL STATUS S M D W 16. SPOUSE'S NAME _____

17. TYPE OF INSURANCE? AUTO WORKER'S COMP PERSONAL INJURY PRIVATE HEALTH MEDICARE NONE

EMPLOYER INFORMATION

1. OCCUPATION _____

2. EMPLOYER _____

3. ADDRESS _____

4. CITY _____ 5. STATE _____ 6. ZIP _____

7. BUSINESS PHONE # (____) _____ 8. FAX # (____) _____

AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. INSURANCE TYPE: AUTO WORK INJURY PRIVATE LIEN _____

2. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD _____

3. DATE OF INJURY _____ 4. DESCRIBE HOW INJURY HAPPENED? _____

5. NAME OF INS. CO. _____ 6. INS. PHONE # (____) _____

7. INS. CO. ADDRESS _____

8. POLICY # _____ 9. CLAIM # _____ 10. WORKER'S COMP. # _____

11. DID YOU REPORT INJURY? NO YES TO WHOM? _____

12. HOSPITALIZED? NO YES WHERE? _____ 13. X-RAYS TAKEN? NO YES BY WHOM? _____

14. WERE YOU WORKING AT THE TIME OF THE ACCIDENT? NO YES 15. DATES LOST FROM WORK _____

16. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY? _____

17. IF AUTO INJURY WERE YOU? DRIVER PASSENGER PEDESTRIAN _____

18. # OF PEOPLE IN YOUR VEHICLE? _____ 19. WORE SEAT BELT? NO YES 20. DID AIRBAG INFLATE? NO YES

21. NAME OF ATTORNEY _____ 22. ATTY'S PHONE # _____ 23. ATTY'S FAX # _____

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. INSURED'S NAME _____ 2. SS# ____ - ____ - ____

3. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD _____

4. NAME OF INSURANCE CO. _____

5. ADDRESS _____

6. INSURANCE PHONE # (____) _____ 7. POLICY# _____

SECONDARY INSURANCE 8. INSURED'S NAME _____ 9. SS# ____ - ____ - ____

10. NAME OF INSURANCE CO. _____

11. ADDRESS _____

12. INSURANCE PHONE # (____) _____ 13. POLICY# _____

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

PATIENT HEALTH INFORMATION

1. MAJOR COMPLAINT(S) _____

2. CHECK YOUR PRESENT AND PAST SYMPTOMS

- | PRESENT | PAST | | PRESENT | PAST |
|--------------------------|--|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> NECK PAIN | | <input type="checkbox"/> | <input type="checkbox"/> EXCESSIVE THIRST |
| <input type="checkbox"/> | <input type="checkbox"/> MIDDLE BACK PAIN | | <input type="checkbox"/> | <input type="checkbox"/> CHRONIC COUGH |
| <input type="checkbox"/> | <input type="checkbox"/> LOW BACK PAIN | | <input type="checkbox"/> | <input type="checkbox"/> CHRONIC SINUSITIS |
| <input type="checkbox"/> | <input type="checkbox"/> HEADACHE | | <input type="checkbox"/> | <input type="checkbox"/> GENERAL FATIGUE |
| <input type="checkbox"/> | <input type="checkbox"/> DIZZINESS | | <input type="checkbox"/> | <input type="checkbox"/> PAINFUL URINATION |
| <input type="checkbox"/> | <input type="checkbox"/> CONVULSIONS | | <input type="checkbox"/> | <input type="checkbox"/> FREQUENT URINATION |
| <input type="checkbox"/> | <input type="checkbox"/> FAINTING, VISUAL DISTURBANCES, NAUSEA | | <input type="checkbox"/> | <input type="checkbox"/> ABDOMINAL PAIN |
| <input type="checkbox"/> | <input type="checkbox"/> SHOULDER PAIN | | <input type="checkbox"/> | <input type="checkbox"/> DIFFICULTY IN SWALLOWING |
| <input type="checkbox"/> | <input type="checkbox"/> PAIN IN UPPER ARMS OR ELBOWS | | <input type="checkbox"/> | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> | <input type="checkbox"/> HAND PAIN | | <input type="checkbox"/> | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> | <input type="checkbox"/> PAIN IN UPPER LEG OR HIP | | <input type="checkbox"/> | <input type="checkbox"/> ANGINA |
| <input type="checkbox"/> | <input type="checkbox"/> PAIN IN LOWER LEG OR KNEE | | <input type="checkbox"/> | <input type="checkbox"/> HEART ATTACK |
| <input type="checkbox"/> | <input type="checkbox"/> PAIN IN ANKLE OR FOOT | | <input type="checkbox"/> | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> | <input type="checkbox"/> SWELLING/STIFFNESS OF JOINTS | | <input type="checkbox"/> | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> | <input type="checkbox"/> JAW PAIN | | <input type="checkbox"/> | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> | <input type="checkbox"/> TINNITUS (EAR NOISES) | | <input type="checkbox"/> | <input type="checkbox"/> EMPHYSEMA (LUNG DISORDERS) |
| <input type="checkbox"/> | <input type="checkbox"/> RAPID HEART BEAT | | <input type="checkbox"/> | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> | <input type="checkbox"/> CHEST PAIN | | <input type="checkbox"/> | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> | <input type="checkbox"/> LOSS OF APPETITE | | <input type="checkbox"/> | <input type="checkbox"/> ULCER |
| <input type="checkbox"/> | <input type="checkbox"/> BLOOD DISORDER | | <input type="checkbox"/> | <input type="checkbox"/> BLADDER INFECTION |
| | | | <input type="checkbox"/> | <input type="checkbox"/> COLITIS |

3. Please describe the character of your current pain: Sharp/Shooting Sharp/Dull Aches Dull Soreness
 Weakness Throbbing/Gnawing Numbness Shooting Gripping/Constricting Burning Tingling

4. Did your problem begin: Due to an accident Multiple incidents Gradually
 No Specific Reason Other _____

5. Describe how your problem began: _____

6. What treatment have you received for this present condition? Surgery Spinal Injections Physical Therapy
 Chiropractic Medicine X-Ray Acupuncture Occupational Therapy Other _____

7. Have you been treated previously for the same condition? Yes No
 If yes, by: MD Chiropractor Physical Therapist Occupational Therapist Other _____

8. What makes your problem better? Nothing Lying Down Walking Standing Sitting
 Movement/Exercise Inactivity Other _____

9. What makes your problem worse? Nothing Lying Down Walking Standing Sitting
 Movement/Exercise Inactivity Other _____

10. Do you work? Yes No If Yes: Sitting more than 50% of workday Light Manual labor
 Manual Labor Heavy Manual Labor Other _____

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

11. Are your complaints affecting your ability to work or otherwise be active?

- No effect Some physical restrictions (able to perform light duty housework and household tasks)
 Need limited assistance with everyday tasks. Need assistance often
 Have a significant inability to function without assistance. Cannot care for self. _____

12. Are you currently taking medication? Yes No If yes: _____

13. Are you allergic to any drugs or medication? Yes No If yes: _____

14. Do you smoke? Yes No How many packs/ Day? _____

15. Do you suffer from any type of allergies? Yes No If yes: _____

16. Have you had any surgery? Yes No If yes: _____

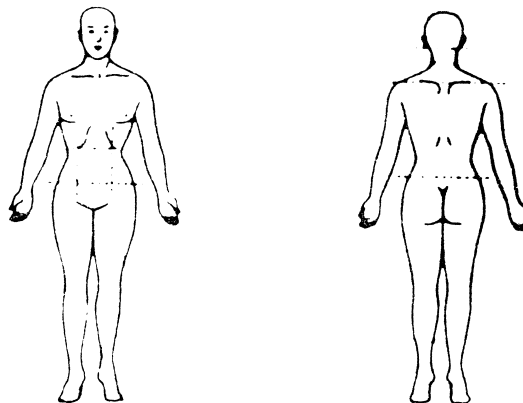
17. Women: Are you pregnant? Yes No Not sure Patient's Initials _____

FAMILY HISTORY

	DIABETES	HEART	KIDNEY	CANCER	BACK	OTHER CONDITIONS
MOTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
FATHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
BROTHER(S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
SISTER(S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

PAIN / SYMPTOMS PICTURE

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN/SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING.



I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

PRIVATE & GROUP ACCIDENT & HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment, except in instances where No-Fault or Workers' Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Name of Patient (Please Print)

Date

Signature of Patient

Signature of Guardian (If Minor)

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to _____
Provider Name

for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature

Date