

Date \_\_\_\_\_

# HEALTH QUESTIONNAIRE

Stately Chiropractic Group

Name \_\_\_\_\_

Purpose of your visit: \_\_\_\_\_

Date of accident / illness: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ am/pm Location: \_\_\_\_\_

How did it occur?  Auto Collision,  On-the -Job,  Other: \_\_\_\_\_

Please describe the circumstances: \_\_\_\_\_

Have you lost time from work?  Yes  No

Have you seen any other doctors for this condition?  Yes  No If yes, who and when: \_\_\_\_\_

Have you had any other significant accidents or injuries?  Yes  No

Please describe the circumstances: \_\_\_\_\_

List Medications or supplements: \_\_\_\_\_

Previous broken bones: \_\_\_\_\_

Previous Hospitalizations or Surgeries \_\_\_\_\_

Have you or any immediate family members had any major disease? Please explain: \_\_\_\_\_

On the following scale, please indicate the severity of your complaint:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Severe Pain

Please indicate:  for Present Complaints

Please indicate:  for Past Complaints

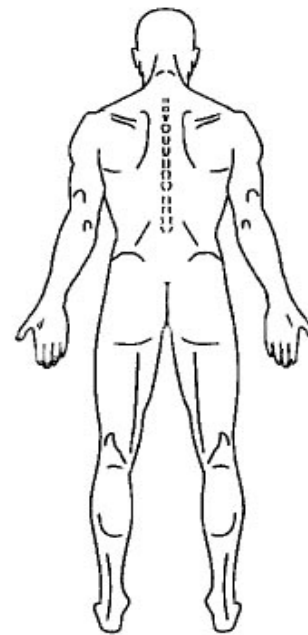
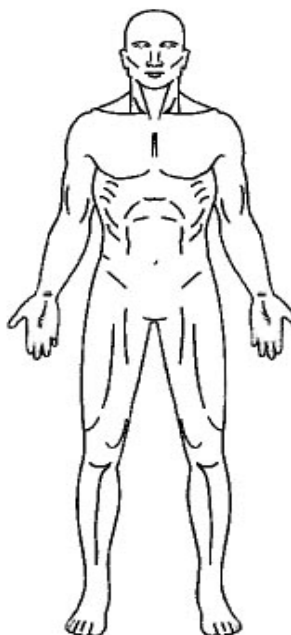
### Musculoskeletal

- Headaches
- Neck problems
- Jaw pain or stiffness
- Jaw clicking
- Shoulder problems
- Arm problems
- Pain between shoulders
- Chest pain
- Lower back problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Tendon ruptures
- Osteoporosis

### Nervous System

- Numbness or tingling
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Sleeping problems
- Nervousness
- Tension or stress
- Loss of memory
- Loss of balance
- Cold hands or feet
- Cold sweats

Please mark the areas of complaint and indicate their priority:



### Gastro-Intestinal

- Poor appetite
- Excessive hunger
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Bloody stool
- Hemorrhoids
- Liver trouble

### Genito-Urinary

- Gall bladder problems
- Weight trouble
- Stomach upset
- Bowel/bladder trouble
- Excessive urination
- Painful urination
- Discolored urine

### Female

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast

### Are You Pregnant?

Yes  No

### Cardiovascular

- Chest pain
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure condition
- Heart problems
- Lung problems
- Varicose veins

### Eyes, Ears, Nose, Throat

- Eye strain
- Vision problems
- Ear pain
- Ringing in ears
- Hearing loss
- Vertigo
- Nose pain
- Nose bleeding
- Sinus problems
- Seasonal allergies
- Dental problems
- Fever
- Loss of smell or taste

# Stately Chiropractic Group

(949) 645-6325 Office

(949) 645-6322 Fax



Last Name: _____	First Name: _____	MI: _____	Birth date: _____	<input type="checkbox"/> M <input type="checkbox"/> F
Today's Date: _____	Referred by: _____	Relation: _____		
Drivers License No.: _____	Expires: _____	Social Security No: _____		
Home Address: _____	Home Phone: _____			
City: _____, CA zip: _____	Cell Phone: _____			
		Work Phone: _____		
		Fax Number: _____		
		Email (home): _____		
Employer: _____	Occupation: _____			
Address: _____	Supervisor: _____			
City: _____, CA zip: _____	Email (work): _____			

Spouses Name: _____	Work Phone: _____
Social Security No.: _____	Fax No.: _____
Employer: _____	Occupation: _____
Address: _____	Supervisor: _____
City: _____, CA zip: _____	Email (work): _____

Emergency Contact Name: _____	Home Phone: _____
Address: _____	Work Phone: _____
City: _____, CA zip: _____	Email: _____

**Acknowledgement and understanding:** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account up receipt. I understand and agree that the portion of the charges due from me will be paid at the time of the office visit. I understand and agree that the portion of the charges due from me will be paid at the time of the office visit. I understand and agree that I will be immediately responsible for paying any amounts that my insurance carrier has not paid within 60 days and that I will be subject to a \$10 billing/late fee for any charges that become 90 days past due.

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

**Consent to treatment of minor:** RE: \_\_\_\_\_(name), a minor. I (we), being the parent(s) or guardian(s), entitled to the care, custody and control of the aforesaid minor, do hereby authorize and direct you to render such treatment to said minor as in your judgment is advisable. It is understood that the above minor may occasionally appear at your office for examination and/or treatment, unaccompanied by an adult, because of my (our) absence or unavailability. This consent will be in effect until terminated by written notice.

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

**Please provide us with a copy of your insurance card and additional information including secondary carrier.**