

Atlantic Coast Chiropractic Patient Questionnaire

Patient Information (please print)

Date: _____

Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Male Female Married Single Widowed Divorced Separated

Birthdate _____ Home Phone _____ Cell _____

Work Phone _____ E-mail Address _____

Employer _____ Occupation _____ #years _____

Emergency Contact _____ Phone _____ Relation _____

Whom may we thank for referring you to us? _____

Name of local primary Physician _____ May we contact them? _____

Insurance Information – If Insured, Please provide copy of insurance card

SYMPTOMS

Main Complaint _____ How Often? _____

When did it start? _____ Getting Worse or better? _____

What activity bothers it the most? _____

When is it at its best? _____ When is it at its worst? _____

Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors? _____ Positive Experience? _____

Other type of physician/therapist? _____ Positive Experience? _____

Secondary Complaint _____

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure	Fibromyalgia	Other _____				

Pertinent Family History _____

Women - How many children? _____ Pregnant? _____ Date of last Menstrual Cycle _____

Nursing? _____ Taking Birth Control Pills? _____

Previous Surgeries and Dates? _____

List ALL Medications you are currently taking _____

What kind of exercise do you do? _____

What supplements do you take? _____

How much do you smoke per day? _____ Drink per week? _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits.

Patient Signature _____ Date _____