

## CONFIDENTIAL PATIENT INFORMATION

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Telephone \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Email \_\_\_\_\_  
 Sex: M F Marital Status: M S W D Age \_\_\_\_\_ Birth Date \_\_\_\_\_ # Children \_\_\_\_\_ Spouse Name \_\_\_\_\_  
 Occupation \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_  
 Name and address of employer \_\_\_\_\_  
 Health Administrator's Name \_\_\_\_\_

### HEALTH INFORMATION

Have you had previous chiropractic care?  Yes  No

Main Complaint \_\_\_\_\_  
 \_\_\_\_\_

Other Complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had similar conditions in the past? \_\_\_\_\_

Does this condition effect your work?  Yes  No

Does this condition effect your family or social life?  Yes  No

What aggravates this condition? \_\_\_\_\_  
 \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_  
 \_\_\_\_\_

Are you taking any medication? \_\_\_\_\_  
 \_\_\_\_\_

What helps your symptoms? \_\_\_\_\_

Have you had any surgery-falls or accidents?  Yes  No

When? \_\_\_\_\_ Please describe \_\_\_\_\_  
 \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

### INSURANCE INFORMATION

Is this condition due to:

A work related injury  Yes  No      An automobile accident  Yes  No  
 If you answer yes to either of the above questions, please complete other side of form.

Are you covered by Medicare? # \_\_\_\_\_

Do you have Major Medical Health Insurance?  Yes  No

Company \_\_\_\_\_

Address \_\_\_\_\_

### Do You Suffer From:

	YES	NO
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problem	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Bronchial Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Morning Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Boylan Chiropractic 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 the **Boylan Chiropractic Office** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date \_\_\_\_\_

Complete only for:

**JOB INJURY INFORMATION:** Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Description of accident \_\_\_\_\_

Workman's Compensation Case # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Insurance Company Case # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Address \_\_\_\_\_

Hospitalized? \_\_\_\_\_ Name of Hospital \_\_\_\_\_ X-rays taken \_\_\_\_\_

Other Doctors seen \_\_\_\_\_

Are you working now? \_\_\_\_\_

Time lost from work \_\_\_\_\_ to \_\_\_\_\_ (dates)

Complete only for:

**ACCIDENT INFORMATION:** Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

How did accident occur?  Auto Collision  Other \_\_\_\_\_

If auto accident, were you  Driver  Passenger  Pedestrian

If auto collision, were you struck from  Behind  Right Side  Left Side  Front  Auto was Parked

Did your car strike the other(s) involved?  Yes  No

Or did the other car strike yours?  Yes  No  Undetermined

As a result of the accident, were traffic citations issued to you?  Yes  No

To the driver of the other car?  Yes  No

To the driver of your car?  Yes  No

List the extent of the injuries as you know them \_\_\_\_\_

Did you require post-accident hospitalization?  Yes  No

Check symptoms you have noticed since accident:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Head Seems Too Heavy     | <input type="checkbox"/> Loss of Memory    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring         | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed      | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Buzzing in Ears   | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Balance   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Loss of Smell     | <input type="checkbox"/> _____         |

Symptoms other than above \_\_\_\_\_

Have you lost any days of work?  Yes  No Dates: \_\_\_\_\_

Insurance Companies involved:

My Company \_\_\_\_\_

Company of person responsible for injuries \_\_\_\_\_

Have you been contacted by an insurance adjuster or company representative regarding this claim?  Yes  No

Do you have an attorney that has advised you in this care?  Yes  No

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone: \_\_\_\_\_