Riverbend Walk-In Chiropractic New Patient Questionnaire

Patient Information

Patient I.D. ________________

Please Print

Name_____________________________ Date_______ SS#__________________

Address______________________City__________ State_______ Zip__________

Seasonal Address____________________City________ State_____ Zip__________

❑Male ❑Female ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated

Birthdate__________ Home Phone_________________ Cell_________________

Work Phone________________ E-mail Address____________________________

Employer_____________________ Occupation__________________ #years______

Business Address____________________City________ State_____ Zip__________

Spouse or Parent's Name____________ Birthdate_______ Phone _______________

Emergency Contact____________ Phone _______________ Relation___________

Whom may we thank for referring you to us? _________________________________

Did you see our Newspaper Flyer?____ Yellow Page Ad? _____ Other?______________

Name of local primary Physician______________________ May we contact them?____

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

SYMPTOMS

Main Complaint_______________________ How Bad?_______ How Often?_______

When did it start?_________________Getting Worse?_______Getting 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 tree - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?__________________ Positive Experience?_________________

Other type of physician or 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_______________________________________

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. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature____________________________________ Date______________