Fairfax Chiropractic Center

Health History Questionnaire

ALL FIELDS ARE REQUIRED Date_____

NAME_____Home Phone (____)_____

ADDRESS_____ALT. Phone (____)_____

CITY _____ STATE_____ ZIP_____ EMAIL_____(optional)

BIRTHDATE_____ AGE_____ SEX ☐ Male ☐ Female SS#_____

EMPLOYER_____ OCCUPATION_____

MARITAL STATUS M S D W SPOUSE'S NAME & AGE _____

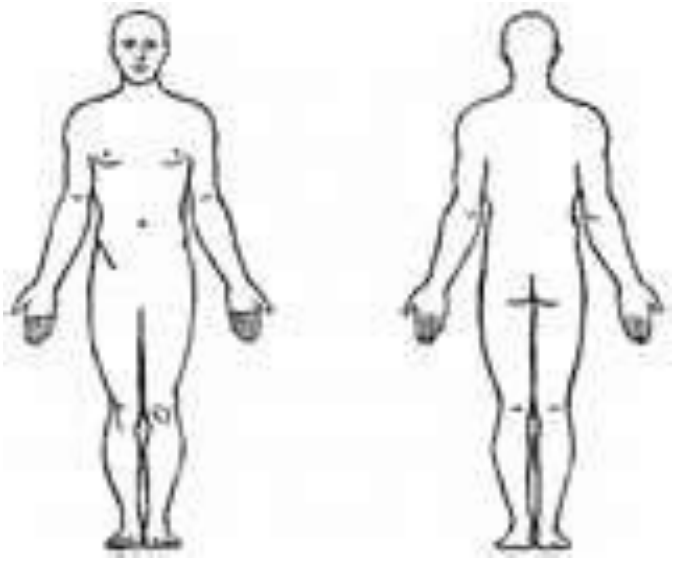
CIRCLE ONE

Have you seen a chiropractor before? Y N Last visit date_____/_____/_____

Most of our Patients are referred to our office by a caring family member or friend. What made you decide to visit our office?

FRIEND / FAMILY MEMBER NAME_____

☐ Sign ☐ Presentation ☐ E-mail ☐ Mailing ☐ Newspaper ☐ Other



Unwanted health condition _____

When did you first notice it? _____

Rate the severity of your pain: 1 minimal – 10 severe pain

1 2 3 4 5 6 7 8 9 10

Write the letters below on the figures to the left to indicate the type and location of your sensations right now:

A = Ache B = Burning N = Numbness

P = Pins & Needles S = Stabbing O = Other

Please answer the following questions to the best of your knowledge.

1.) Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ ☐ NEVER

2.) When your last spinal exam, including x-rays? _____ ☐ NEVER

3.) Have you ever been told that you have vertebral subluxations, spinal curvature, spinal arthritis, or inherited spinal problems? ☐ NO ☐ YES, Please explain _____

4.) Subluxation or spinal misalignment can cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head, low back, or hips? ☐ NO ☐ YES

5.) Spinal misalignments or subluxations can make you feel like you need to twist, stretch, or crack your neck and back. Do you ever feel the need to "crack and pop" your neck and lower spine? ☐ NO ☐ YES

6.) Poor posture leads to poor health, and often indicates spinal problems. How would you rate your posture?

POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

7.) Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

LOW 1 2 3 4 5 6 7 8 9 10 HIGH

8.) Chiropractic care is optimal health and healing. However, most of our patients first seek our help when in a health crisis. What health concerns or crisis brought you to our office?

1._____ 2._____ 3._____

9.) Prescription medications may cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. What medications are you currently taking? _____
_____

10.) Auto and work related injuries can cause serious spinal problems (even if not reported). When was your last auto accident? _____

11.) Spinal health is especially important during pregnancy. Is there any chance of pregnancy? ☐ NO ☐ YES

12.) If the doctor feels chiropractic care will help you, are you willing to follow his recommendations? ☐ YES ☐ NO

13.) Although most health insurance is for emergency care rather than health care, many companies offer chiropractic benefits. Do you have insurance that you believe will contribute to your chiropractic expenses?
☐ YES ☐ NO Name of Insurance Company _____

14.) Many people with spinal problems experience health crises before seeking chiropractic care. Have you had any major hospitalizations or surgeries that the doctor should know about? ☐ YES ☐ NO

If yes, please explain: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ YES ☐ NO

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat

- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FEMALES ONLY:

When was your last period? _____

Are you pregnant? ☐ NO ☐ YES

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems

- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems:

_____

_____

_____

AUTHORIZATIONS

I hearby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds to any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident 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 upon receipt. However, I clearly understand and agree that all services rendered to 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 products or professional services rendered will be immediately due and payable.

Patient Signature_____ Date_____

Patient Signature_____ Date _____