SUBURBAN CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT INFORMATION

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

Full Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____ Marital Status: M S W D

Date of Birth: Month _____ Day _____ Yr _____ # Children _____ Spouse's Name _____

Occupation _____ Whom may we thank for referring you _____

FEMALES: Are you pregnant? _____ Email Address _____

HEALTH INFORMATION

Have you had previous chiropractic care? Yes ☐ No ☐

Reason for this visit _____

_____

Other complaints _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

Does this condition affect your work? Yes ☐ No ☐

Does this condition affect your family or social life? Yes ☐ No ☐

What aggravates this condition? _____

_____

Other Doctors seen for this condition _____

_____

Are you taking any medication? Yes ☐ No ☐

If so, what kind? _____

What helps your symptoms? _____

Have you ever had surgery? Yes ☐ No ☐ When _____

Please describe _____

Have you ever broken any bones? 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 page 2.

Are you covered by Medicare? # _____

Do you have Major Medical Health Insurance? Yes ☐ No ☐

Company _____

Who will be responsible for payment? _____

Do You Suffer From	Yes	No
Headaches	☐	☐
Neck Pain	☐	☐
Arm Pain	☐	☐
Shoulder Pain	☐	☐
Back Pain	☐	☐
Leg Pain	☐	☐
Chest Pain	☐	☐
Abdominal Pain	☐	☐
Hip Pain	☐	☐
Sinus Problems	☐	☐
Heart Problems	☐	☐
Circulatory Problems	☐	☐
High/Low Blood Pressure	☐	☐
Female Problems	☐	☐
Prostate Disorder	☐	☐
Kidney Problems	☐	☐
Bladder Problems	☐	☐
Lung/Bronchial Disorders	☐	☐
Digestive Disorder	☐	☐
Constipation	☐	☐
Loose Stool	☐	☐
Diabetes	☐	☐
Swollen Joints	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Nervousness	☐	☐
Depression	☐	☐
General Fatigue	☐	☐
Anemia	☐	☐
Poor Memory	☐	☐
Hot Flashes	☐	☐

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, [understand that the Suburban Chiropractic Center 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 Suburban Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly tome 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's Signature if Under 18: _____ **Date:** _____

Information Taken By: _____ **Date:** _____
(If someone else completes form)

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 not an auto collision, please describe the circumstances: _____

_____

_____

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 youhave noticed since accident:

☐ Headache	☐ Dizziness	☐ Light Bother Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐ _____

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 ever 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 case? Yes ☐ No ☐

Name _____

Address _____ Telephone _____