

NEW PATIENT HEALTH QUESTIONAIRE
New Smyrna Beach Chiropractic Clinic, PLC

Date: _____ Patient's Name: _____
SSN: _____ Sex: M F Age: _____ Birth Date (MM/DD/YYYY): _____
Height: _____ Weight: _____ Right Handed Left Handed

Home Address (Street, City, Postal Code): _____

Telephone: Home: _____ Bus: _____ Cell: _____ Email Address: _____

INSURANCE INFO: CO. Name: _____ Address: _____
Phone #: _____ Group#: _____ Insured's Name: _____
Relation: _____ DOB: _____ Insured's Employer: _____

Referred By: _____

Have you ever had previous chiropractic care? Y N If so when: _____ With Whom? _____

Primary Care Physician: _____ Office Phone Number: _____ Date of Last Visit: _____

Are there recent X-Rays, MRI's, or CT Scans available? Y N
Date Taken? _____ Where? _____

ABOUT YOUR PAIN:

- Date pain started? _____ How did it occur? _____
- Where does it hurt? _____ Have you ever had this before? Y N when? _____
- Is the problem getting: worse no change better
- Any pain at night? Y N Does coughing, sneezing or straining aggravate the pain? Y N

How would you rate the pain?

1 = I feel no pain 10 = I hurt so bad I could go to the hospital
1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY:

Have you ever: (Be as accurate as possible)

- Had an accident (car, fall, sports, other)? Y N
 If Yes, please tell us about it: _____
- Had an operation? Y N Describe (WITH DATES): _____
- Been hospitalized? Y N Describe (WITH DATES): _____
- Major illness? Y N Describe (WITH DATES): _____

Please list any and all medication or herbal supplements and reason for taking: _____

FAMILY HISTORY:

Do you have any family history in your mother, father, siblings or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE? Y N Please list conditions not mentioned: _____

If yes: Who? _____ What conditions? _____ Age Deceased? _____

SOCIAL HISTORY:

Smoke? Y N pks/day? _____ Alcohol? Y N drinks/day? _____
Exercise? Y N times/wk? _____ Sleep _____ hrs/day on: back left side right side stomach
How would you describe your stress level? minimal moderate severe intolerable

Health History Questionnaire (PLEASE MARK ALL PAST/PRESENT CONDITIONS AS THIS SECTION IS VERY IMPORTANT)

Please **circle** any conditions you currently have and place an **"X"** on the line if you have had this condition in the past.

General

- Chronic Fever
- Chills
- Night Sweats
- Loss of Sleep
- Chronic Fatigue
- Nervousness
- Weight Loss/Gain**
- Allergies
- Bleeding Problems
- Anemia
- Diabetes**
- Cancer**
- Thyroid Disease
- High Cholesterol**
- Osteoporosis**
- Alcoholism
- Drug Abuse

Cardiovascular

- Irregular Heartbeat
- High Blood Pressure**
- Pain in Chest
- Heart Disease**
- Ankle Swelling
- Varicose Veins
- Stroke**
- Heart Attack**
- Heart Murmur

Neurological

- Weakness**
- Twitching
- Tremors
- Chronic Headaches
- Fainting
- Dizziness
- Convulsions
- Epilepsy**
- Numbness/Tingling**
- Arm/Leg Pain
- Mental Disorder

Eyes, Ears, Nose, Throat

- Poor Vision
- Pain in eye(s)
- Deafness/Difficulty hearing
- Nosebleeds
- Nose Problems
- Sinus Problems
- Hoarsness
- Difficulty Swallowing
- Dental Problems
- Reccurent Ear Infection

Genitourinary

- Frequent Urination
- Painful Urination
- Blood in Urine**
- Urinary Infection
- Kidney Disease**
- Inability to Control Urine**
- Difficulty Starting Urine Flow**
- Frequent Night Urination
- Breat Lumps or Pain
- Venereal Disease
- Sexual Dysfunction
- Kidney Stones

Musculoskeletal

- Neck Stiffness/Pain
- Pain between shoulder blades
- Low Back Pain
- Swollen Joints
- Stiff/Painful Joints
- Muscle Aches/Sorness
- Spinal Curvature
- Arthritis
- Knee Pain
- Shoulder Pain
- Wrist/Hand Pain
- Ankle/Foot Pain
- Radiating Pain into Arms**
- Radiating Pain into Legs**
- Disc Herniation**
- Disc Bulge

GastroIntestinal

- Poor Appetite
- Poor Digestion
- Belching or Gas
- Chronic Nausea
- Vomiting Blood
- Pain over Abdomen
- Ulcer
- Black or Bloody Stool
- Liver Problems**
- Gallbladder Problems
- Jaundice
- Hernia
- Chronic Diarrhea
- Chronic Constipation
- Hemorrhoids
- Appendicitis

Skin

- Itchy/Dry/Flaky
- Bruise Easily
- Change in Mole
- Skin Cancer
- Rashes
- Abnormal Scars
- Inability to stop bleeding

Habits/Exercise

- Smoking ___pks/day
- Alcohol ___drinks/wk
- Recreational Drug Use
- Exercise _____ times/wk
- Caffeinated drinks __ drinks/day
- Water _____ cups/day

Respiratory

- Difficulty Breathing**
- Chronic Cough
- Coughing up Phlegm
- Coughing up Blood
- COPD**
- Asthma
- Pneumonia
- Tuberculosis
- Emphysema**

Male Only

- Testicular Swelling
- Prostate Problems**
- Undescended Testicle
- Painful Intercourse

Other

- Memory Loss
- Concentration Loss
- Convulsions
- Vertigo
- Chronic Fatigue
- Osteoporosis
- Fibromyalgia
- Aneurysm
- HIV/AIDS**
- Fibromyalgia**
- Recent UNINTENTIONAL weight loss**

Please list all other past medical diagnosis: _____

WOMEN ONLY:

- excessive menstruation
- irregular cycle
- hot flashes
- breast pain/lumps
- painful menstruation
- painful intercourse
- other _____

ANY CHANCE YOU ARE PREGNANT? Y N HOW MANY MONTHS? _____

LAST DAY OF LAST MENSTRAL CYCLE? _____ DATE OF LAST PAP TEST? _____

My Healthcare Benefits:

I fully understand when the insurance company verifies my benefits **IT IS NOT A GUARANTEE OR AUTHORIZATION TO PAY ON CLAIMS SUBMITTED.** I agree to pay my patient portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied and unpaid claim. I further understand all claims submitted by this office are my responsibility and require my participation to settle regardless of my insurance company or assignment of benefits.

_____/____/____
Signature of Patient or Parent/Guardian Date

Treatment Authorization and Assignment of Benefits:

This office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the release of any medical information necessary to process and to secure payment of benefits. I authorize payment directly to New Smyrna Beach Chiropractic Clinic, PLC/ Dr. Amanda Prokop, D.C. of the "Health Benefits", "Medical Reimbursement" from a Third Party Payer and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly. Should collection of past due amount become necessary, I will become responsible for all charges, fees, and attorney fees. I authorize the use of this signature on all insurance submissions and I certify my sole purpose of entering this office is for healthcare.

_____/____/____
Signature of Patient or Parent/Guardian Date

Consent to Treat a Minor:

I (we) being the parents, guardian, or custodian of the minor being _____, Age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

_____/____/____
Signature of Patient or Parent/Guardian Date

I have completed the above information to the best of my knowledge. I authorize New Smyrna Beach Chiropractic Clinic, PLC to release any information concerning my health and health care services to my insurance companies. I hereby assign all medical benefits to which I am entitled, private insurance, Medicare, and any other insurance program to New Smyrna Beach Chiropractic Clinic, PLC and I direct that payment be made directly New Smyrna Beach Chiropractic Clinic 665 N. Dixie Freeway New Smyrna Beach, FL 32168. A photocopy of this assignment is to be considered as valid as original. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges, whether or not paid/covered by said insurance, and that I will be responsible for any amounts uncollected by New Smyrna Beach Chiropractic Clinic, PLC.

_____/____/____
Signature of Patient or Parent/Guardian Date

New Smyrna Beach Chiropractic Clinic, PLC