

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 _____ Age _____ Birthdate _____ Marital Status: M S W D
 Work Telephone _____ # Children _____
 Spouse's 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"/>
Prostrate 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	<input type="checkbox"/>	<input type="checkbox"/>
Disorder 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 Problemsd | <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: _____