

WOLF CHIROPRACTIC CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form.
If you need assistance, please ask our receptionist, and we will be happy to help you.

Your Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ SS#: _____ E-mail: _____

Marital Status: M S D W Drivers License #: _____ State _____

Your Occupation: _____ Employed by: _____

Address: _____ City: _____ State _____ Zip _____

Work Phone: _____

Your Spouse's Name: _____ DOB: _____

Spouse Occupation: _____ Employed by: _____

Spouse's work phone #: _____ Spouse SSN: _____

Emergency Contact: _____ Phone No: _____

Name of nearest relative not living with you: _____

Their phone number: _____

How did you hear about this office? _____

Primary Care Physician: _____ Phone #: _____

Address _____

May we send them a report regarding your condition? Yes No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Wolf Chiropractic Center, PS Inc. 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 Wolf Chiropractic Center 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. I also understand that a finance charge will be billed to any unpaid services on a monthly basis. I also understand that any services 90 days and older will be sent to a collection agency and all collection agency fees are my responsibility.

I attest that the above information is true and correct to the best of my knowledge. I also understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: _____ Date: _____

Parent or Guardian: _____

Signature: _____ Date _____

Present Complaints (please circle the appropriate ones) Page 2

Headache	Feet/hands cold	Head seems heavy	Pins and needles in arms
Mental dullness	Depression	Confusion	Right / Left
Loss of memory	Pins and needles in arms	Constipation	Pins and needles in hands
Dizzy	Rib pain	Unbalanced	Right / Left
Neck Pain	Neck stiffness	Chest pain	Pins and needles in legs
Fainting	Shortness of breath	Ears ringing/buzzing	Right / Left
Upper back pain	Upper back stiffness	Midback pain	Midback stiffness
Lower back pain	Lower back stiffness	Blurred vision	Double vision
Neck restriction	Eye strain / pain	Loss of taste	Loss of smell
Nervousness	Fear	Irritability	Tension

What is your primary reason for seeking care in this office? _____

Does this condition cause:

- Difficulty in: Standing, Sitting, Bending, Walking
- Pain radiation to the: Right arm, Left arm, Right leg, Left leg
- Cannot lift: Light, Moderate, Heavy, Repetitive
- Pain radiating to: Neck, Base of skull, Ribs, Shoulders, Arms
- Pain in the: Foot, Ankle, Knee, Hip, Heel spurs
- OTHER: _____

Has the problem interrupted your sleep? Yes / No How: _____

Are you taking any medication for this condition? If so what medications? _____

Does anyone in your family have the same or similar condition: Yes / No

Who: _____ What Condition: _____

Care they are receiving: _____

Is it helping? Yes / No May we contact them regarding their condition: Yes / No

List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____

Since the time this (these) complaint(s) began, what, if anything, have you tried that **did not** work? _____

Patient Name: _____ **Date:** _____

List any operations that you've had and approximate dates:

- 1. _____ Date: _____ Dr: _____
- 2. _____ Date: _____ Dr: _____
- 3. _____ Date: _____ Dr: _____
- 4. _____ Date: _____ Dr: _____

Are you allergic to any medication? Please list: _____

Are you taking any medications? Please list: _____

Do you: Smoke: Yes No Amount per day: _____

 Drink: Yes No Light Medium Heavy

 Exercise: Yes No Never Sometimes Frequently Regularly

WOMEN ONLY: Are you pregnant? Yes No If yes, due date: _____

Date of last menstrual period: _____

ADDITIONAL INFORMATION THAT YOU FEEL THE DOCTOR NEEDS TO KNOW:

Patient Name: _____

Date: _____

