Robson Chiropractic New Patient Questionnaire

Patient Information

Patient I.D. _____

Please Print

Name_____ Date_____ SS#_____

Address_____ City_____ State_____ Zip_____

Seasonal Address_____City_____ State____ Zip_____

❑Male ❑Female ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated

Birthdate_____ Home Phone_____ Cell_____

Work Phone_____ E-mail Address_____

Employer_____ Occupation_____ #years_____

Business Address_____City_____ State____ Zip_____

Spouse or Parent's Name_____ Birthdate_____ Phone_____

Emergency Contact_____ Phone _____ Relation_____

Whom may we thank for referring you to us? _____

Name of local primary Physician_____ May we contact them?_____

Insurance Information – *If Insured, Please provide copy of insurance card*

SYMPTOMS

Main Complaint_____ How Often?_____

When did it start?_____ Getting Worse?_____ Getting Better?_____

What activity bothers it the most? _____

When is it at its best?_____ When is it at its worst?_____

Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_____ Positive Experience?_____

Other type of physician or therapist?_____ Positive Experience?_____

Secondary Complaint_____

Health History - *Please circle all that apply*

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other_____			

Women - How many children?____Pregnant?____Date of last Menstrual Cycle_____

Nursing?_____ Taking Birth Control Pills?_____

Previous Surgeries and Dates? _____

List ALL Medications you are currently taking _____

_____

What kind of exercise do you do? _____

What supplements do you take?_____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature_____ Date_____