Health Solutions

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Welcome to our office. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in improving and maintaining your health.

Patient Information

Today's date: ______/______/______

Name____ Social Sec. # _______-______-________
Last First Initial

Address ___________________________________City ____________________ State ________ Zip ____________

Phone #: (_____)______-_________ Cell Phone #: (_____)______-________ Sex ☐ M ☐F Age _____ Birth Date ____/_____/_____

☐ Single ☐ Married ☐ Separated ☐ Divorced **Email address**: ____

Patient employed by ___________________________________ Occupation ______________________________________

Business Address ____ Business Phone # (_____)_______-_________

Whom may we thank for referring you to our office? ____

Notify in case of emergency ____________________________ Relation __________________ Phone (______)______-________

Primary Insurance

Primary Insured: _________________________ _____________________ _______ _________________________
Last Name First Name Initial Relation to Patient

Date of Birth: ______/______/______ Social Sec. # _______-_______-_________ Phone #: (____)_____-_______

Reason for Visit

Have you ever seen a chiropractor? ☐Yes ☐No If yes, when and why? ____

Describe your **PRIMARY** complaint and its location: ____

When did symptoms begin? _______________________________ Have you had this condition in the past? ☐Yes ☐No

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____________________

Have you been treated by a medical physician or any other professional for this condition? ☐Yes ☐No If yes, state name of doctor, also when and where? ____

Activities or movements difficult /painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting ☐ Standing

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other ____

Is your pain interfering with**:** ☐ **Work** ☐ **Sleep** ☐ **Daily Routine** ☐ **Recreation**

Is there anything that makes the condition worse?____

Any **OTHER** areas of pain or discomfort not mentioned above: ____

____

Health History

Please list any medications (including pain killers) you are taking: ____________________

____

Please list & date any recent or past injuries/surgeries/auto accidents (i.e.: falls, broken bones, traumas, etc.): ____________________

____

List recreational activities and/or sports that you currently are involved in or have been involved in the past? ____________________

____

Women: Are you pregnant? ☐ Yes ☐ No If so, how far along? ____________________ Nursing? ☐ Y ☐ N
Due date: ____________________

Medical Conditions

Please check all of the following health conditions that apply to **YOU**?

☐ Heart Attack/Stroke	☐ Neck Pain	☐ Wrist Pain	☐ Ulcer/Colitis	☐ Arthritis	☐ Severe Frequent Headaches
☐ Congenital Heart Defect	☐ Jaw Pain	☐ Arm Pain	☐ Ringing Ears	☐ Hepatitis	☐ Seizures/Epilepsy
☐ High Blood Pressure	☐ Shoulder Pain	☐ Shingles	☐ Dizziness	☐ High Cholesterol	☐ Psychiatric Issues
☐ Diabetes/Tuberculosis	☐ Low Back Pain	☐ Cancer	☐ Fainting	☐ Kidney Problem	☐ Difficulty Breathing
☐ Freq. Colds/Earaches	☐ Leg Pain	☐ Anemia	☐ Gout	☐ Alcohol/Drug Abuse	☐ HIV(+)/ AIDS/ STD's
☐ Artificial Bones/Joints	☐ Emphysema/Glaucoma		☐ Tingling, where? ____________________		
☐ Numbness, where? ____________________			☐ Muscle Spasms, where? ____________________		

Lifestyle Information

Please list all nutritional supplements you are presently taking. ____________________

Are you aware of any allergic/sensitivity reactions toward any food items, air-borne particles, chemicals, perfumes, etc? ☐ Yes ☐ No

If yes, please list: ____________________

____

How much water do you drink in a day? ____________________ How much do you exercise and what type? ____________________

____

How do you rate your stress levels from 1-10 (1 – Lowest, 10 – Highest)? ____________________

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by **Health Solutions** to help determine appropriate health services. If there is any change in my medical status, I will inform the doctor immediately.
I also understand that all patient related information is kept strictly confidential by Health Solutions and released only by prior authorization of the patient or a legal guardian of the patient

I authorize my insurance company to pay Health Solutions all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Health Solutions to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____________________ **Date** ______/______/______

****Payment is due in full at the time services are rendered unless prior arrangements have been approved.****