Patient Questionnaire – Non-Accident

Patient Name: _____ Today's Date: ____/____/____

Social Security Number _____ Birth Date: ____/____/____ Age: _____ Gender: F M

Best Phone numbers to reach you: Phone: (_____) _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Mother: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Guardian: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Who do you normally live with? □ Mother and Father □ Father □ Mother □ Legal Guardian □ None of these

Marital Status: □ Married □ Separated □ Widowed □ Single How many children? _____

CURRENT ADDRESS

Street _____City _____ State _____ Zip _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____City _____ State _____ Zip _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ □ FULL-TIME □ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ____/____/____

Spouse's Occupation _____ Work Phone (_____) _____

Spouse's Work Address _____-_____ Work Phone (_____) _____--_____

Spouse is a student at _____ □ FULL-TIME □ PART-TIME

Who should we contact in the event of an emergency? _____

Phone (_____) _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? □ YES □ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? □ YES □ NO

Did it result from a *work-related* accident or cause? □ YES □ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Will you be using insurance for the visit today? □ Yes □ No

General Information Related to the Condition:

Describe the conditions, symptoms or purpose of the appointment:

_____

_____

Approximately when did the conditions or symptoms begin to occur? ____/____/____

□ No particular condition or symptoms -- Just seeking general good health

Additional Information Related to the Condition:

PLEASE FILL OUT ATTACHED HEALTH CONDITION FORM TO GIVE MORE DETAILED INFORMATION ABOUT YOUR CONDITION OR CONDITIONS.

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	____/____/____
_____	_____	____/____/____

Please check any of the following symptoms you are now experiencing:

□ Headache
□ Dizziness
□ Light Bothers Eyes
□ Diarrhea
□ Head seems too heavy
□ Neck Pain
□ Loss of Memory
□ Clumsiness
□ Feet Cold
□ Neck Stiff
□ Tingling in arms/hands
□ Ears Ring
□ Hands Cold
□ Sleeping Problems
□ Tingling in legs/feet
□ Face Flushed
□ Nausea
□ Back Pain
□ Numbness in arms/hands
□ Buzzing in Ears
□ Constipation
□ Nervousness
□Numbness in legs/feet
□ Loss of Balance
□ Cold Sweats
□ Tension
□ Shortness of Breath
□ Fainting
□ Fever
□ Fatigue
□ Irritability
□ Loss of Smell
□ Chest pain/rib pain
□ Pain in arms/hands
□ Pain in legs/feet
□ Jaw pain
□ Loss of strength – arms
□ Burning muscle pain
□ Loss of strength – legs
□ Difficulty swallowing
□ Sharp/shooting pain
□ Other
_____
_____
_____

Have you experienced changes to:

□ Eyes (sight) □ Ears (hearing) □ Nose (smell) □ Mouth (taste) □ Bladder
□ Bowels □ Sleep □ Emotion □ Appetite

Please Explain:

_____

Have you missed work or school due to your injuries? □ Yes □ No

Do you smoke? □ Yes □ No Number of packs: _____

Do you drink alcohol? □ Yes □ No Number of Drinks _____

Medical History:

Do you now or have you ever had:

□ Heart Disease
□ Diabetes
□ Cancer
□ Stroke
□ High Blood Pressure
□ Thyroid Problems
□ Tuberculosis
□ Prostate Disorder
□ Kidney Problems
□ Asthma
□ Ulcer
□ Seizure Disorder
□Other:_____
□Other:_____
□Other:_____

Medical History:

Have you ever been in our office before? □ Yes □ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date :

1) _____ ____/____/____

_____

_____

2) _____ ____/____/____

_____

_____

3) _____ ____/____/____

_____

_____

4) _____ ____/____/____

_____

_____

Surgeries/Hospitalizations:

_____

_____

_____

Allergies (please list all):

_____

_____

Medications (please list all):

_____

_____

Supplements (please list all):

_____

_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN

Insurance information:

Will you be using insurance for the visit today? □ Yes □ No

Name of Insurance Company: _____ Member ID #: _____

Who is responsible for the account? □ Self □ Parent/Guardian

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ____/____/_____

Does the policy holder have the insurance through his/her employer? □ YES □ NO

If yes, who is the employer? _____

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/____/_____