

# OPTIMUM CHIROPRACTIC

## CONFIDENTIAL PATIENT INFORMATION

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Full Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Marital Status: M S W D  
Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_ # Children \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Occupation \_\_\_\_\_ Whom may we thank for referring you \_\_\_\_\_  
FEMALES: Are you pregnant? \_\_\_\_\_ Email Address \_\_\_\_\_

### HEALTH INFORMATION

Have you had previous chiropractic care? Yes  No   
Reason for this visit \_\_\_\_\_  
\_\_\_\_\_  
Other complaints \_\_\_\_\_  
How long have you had this condition? \_\_\_\_\_  
Have you had similar conditions in the past? \_\_\_\_\_  
Does this condition affect your work? Yes  No   
Does this condition affect your family or social life? Yes  No   
What aggravates this condition? \_\_\_\_\_  
\_\_\_\_\_  
Other Doctors seen for this condition \_\_\_\_\_  
\_\_\_\_\_  
Are you taking any medication? Yes  No   
If so, what kind? \_\_\_\_\_  
What helps your symptoms? \_\_\_\_\_  
Have you ever had surgery? Yes  No  When \_\_\_\_\_  
Please describe \_\_\_\_\_  
Have you ever broken any bones? 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 page 2.  
Are you covered by Medicare? # \_\_\_\_\_  
Do you have Major Medical Health Insurance? Yes  No   
Company \_\_\_\_\_  
Who will be responsible for payment? \_\_\_\_\_

### Do You Suffer From

	Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung/Bronchial Disorders	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

I hereby authorize release of information necessary to file a claim with my insurance company and or attorney and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. 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.

A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature if Under 18: \_\_\_\_\_ Date: \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_  
(If someone else completes form)

**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 not an auto collision, please describe the circumstances: \_\_\_\_\_

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 Problems | <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"/> _____         |
| <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Depression               | <input type="checkbox"/> Loss of Taste     | <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 ever 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 case? Yes  No

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_