United Integrated
Healthcare Center

NEW CHIROPRACTIC PATIENT QUESTIONNAIRE

Patient# _____ Date _____

NAME _____ DATE OF BIRTH _____
ADDRESS _____ HOME PHONE _____
CITY/ST _____ ZIP _____ CELL PHONE _____
OCCUPATION _____ WORK PHONE _____
E-MAIL ADDRESS _____
MARRIED____ SINGLE____ WIDOW(ER)____ DIVORCED____ NUMBER OF CHILDREN_____

SPOUSE _____ EMPLOYMENT _____ WORK # _____

Whom may we thank for referring you to us? _____

Personal Habits
Are you currently using any: ____Medications ____ Drugs ____ Tobacco ____ Alcohol
____ Coffee ____ Vitamins/Minerals/Herbs ____ Exercise

List all medications you are currently taking _____
_____.

Present Health Condition
Height _____ Weight _____ Have you experienced any significant weight change in the past three months? ___ Yes ___ No.
If yes, please describe change _____.

Please list your symptoms below in order of importance and give date symptoms began.

1._____Date_____
2._____Date_____
3._____Date_____
4._____Date_____

Is this condition due to an auto accident?___Yes___No. If yes, list date of accident_____. Who was at fault? _____
_____.
Is this condition a direct result from an injury which occurred at work?__Yes__No. If yes, date and time of injury _____
_____. Did you report this injury to your employer?__Yes__No.

Do you have health insurance?__Yes__No. If Medicare, please present your insurance card at the front desk.

In case of an emergency who should be contact? Name_____Daytime phone #_____
Relationship?_____

*I understand and agree that all services are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend/terminate my care, all fees for services will be immediately due. Payment is expected at time of visit.

Patient/Guardian Signature:_____ Date_____

If under 18, parental consent required: I (please print)_____ give United Integrated Healthcare Center Permission to treat my son/daughter with chiropractic care. **Parent/Guardian signature:**_____

Please complete Health History on back of this page

Health History

Have you ever had the same or similar symptoms? ___Yes___No. If yes, when? _____
Have you had treatment by another doctor for these symptoms? ___Yes___No.
If yes, name of doctor _____.
Is there any family history of this type of pain? ___Yes___No.
Have you had any previous Chiropractic care? ___Yes___No.
Have you ever been hospitalized? ___Yes___No. If yes, when and why? _____.
Have you ever broken any bones? ___Yes___No. If yes, when and what? _____
_____.
Have you noticed any recent changes in bowel or bladder habits? ___Yes___No. If yes, please describe _____
_____.

Please check below if you or a member of your family has ever been diagnosed with or suffered from:

You	Family	Relationship (Father, Mother, Sister ...)	
_____	_____	_____	1. Cancer
_____	_____	_____	2. Diabetes
_____	_____	_____	3. Thyroid Disease
_____	_____	_____	4. Hypertension (High Blood Pressure)
_____	_____	_____	5. Hypercholesterolemia (High Cholesterol)
_____	_____	_____	6. Atherosclerosis (Heart Disease)
_____	_____	_____	7. Kidney Disease
_____	_____	_____	8. Osteoporosis
_____	_____	_____	9. Neuromuscular Disease (i.e. Parkinson's, Multiple Sclerosis)
_____	_____	_____	10. Rheumatoid arthritis
_____	_____	_____	11. Allergies/Asthma
_____	_____	_____	12. Scoliosis
_____	_____	_____	13. Low back pain/or surgery
_____	_____	_____	14. Headache/Migraine
_____	_____	_____	15. Gastrointestinal Problem (Gallbladder, Ulcers, Diverticulitis)
_____	_____	_____	16. Liver Disease (Hepatitis, Cirrhosis)
_____	_____	_____	17. Other _____

Please notify the Doctor if you suffer from any medical condition not listed on this form.

Female Health History
Date of last menstrual cycle_____. Was it ___regular or ___irregular?
Is there any possibility that you are pregnant? ___Yes___No___Maybe
Are you using some form of birth control pill? ___Yes___No. If yes, what kind _____.
Do you have an annual gynecological exam? ___Yes___No.
If over 40, do you have a regular mammogram? ___Yes___No

Male Health History
Do you have a regular prostate exam? ___Yes___No
Have you had a recent Prostate Specific Antigen test? ___Yes___No

Primary Care Provider
Do you have a primary care physician? ___Yes___No.
Doctor's name: _____ Phone #: _____
Office Address:_____.
FAX: _____

If you would like us to send any records from your visits at United Integrated Healthcare Center to your primary physician, please ask for a release of records form at the front desk, and be sure to provide us with the doctor's name and fax number.