

New Patient Questionnaire

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ SS# _____

Home Phone _____ Cell _____ Work Phone _____

E-mail Address _____ For HealthUpdate Newsletter-You will receive a confirmation email

Employer _____ Occupation _____

Spouse or Parent's Name _____ Phone _____

Emergency Contact _____ Phone _____ Relation _____

How did you hear about this office? _____

Name of local primary physician _____ May we send a report? Yes No

Main Complaint: _____

Secondary Complaint(s): _____

Height _____ ft. _____ in. Weight _____ lbs. List drug allergies _____

Health History - Please check all that apply

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Chronic Fatigue
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Fractures	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter
<input type="checkbox"/> Gout	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Herpes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Migraines	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mono	<input type="checkbox"/> M.S.	<input type="checkbox"/> Mumps
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Polio	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Prostate	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Implants
<input type="checkbox"/> Rheumatoid	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors	<input type="checkbox"/> Typhoid	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Whopping Cough	Other: _____						

Previous Surgeries and Dates: _____

List ALL Medications you are currently taking: _____

What kind of exercise do you do? _____

What supplements do you take? _____

How much do you smoke per day? _____ Alcoholic drink(s) per week? _____

*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 _____