

**GENERAL INFORMATION**

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

Name \_\_\_\_\_ MI \_\_\_\_\_ Sex: M F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ How did you hear of our office? \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Spouse/Insured Name: \_\_\_\_\_

Cell: \_\_\_\_\_ Spouse/Insured SS#: \_\_\_\_\_ DOB# \_\_\_\_\_

Email: \_\_\_\_\_ Spouse/Insured Occupation: \_\_\_\_\_

Marital Status: Married Single Widowed Divorced Spouse/Insured Employer: \_\_\_\_\_

Spouse/Insured Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize Express Your Health to disclose the following health information:  Appointment information  
 Appointment and Financial information  
 All information

Parents: \_\_\_\_\_  Spouse: \_\_\_\_\_  Other: \_\_\_\_\_

This authorization shall be in effect until revoked. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Express Your Health.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**Who is responsible for your bill?**  Self  Parent  Workers' Comp  Auto Insurance  Medicare

Health Insurance (Name) \_\_\_\_\_ Policy # \_\_\_\_\_

**Is this a work/accident related injury?** \_\_\_ Yes \_\_\_ No Was this reported to your employer? \_\_\_ Yes \_\_\_ No

Date of Injury: \_\_\_\_\_ Date last worked: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Claim#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Our office will file claims with the insurance information that you have provided. Failure to provide accurate coverage information could result in non-payment of your claim. Remember that you are responsible for all charges regardless of insurance coverage*

**FOR MESSAGE CLIENTS:**  
**Cancellation Policy:** For a massage therapy appointment that is cancelled with less than a 24-hour notice, half of the session fee will be charged. This fee is not billable to insurance.  
**Massage Policy:** I agree to the posted massage policy. Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**RECORDS RELEASE**

As a professional courtesy, I authorize Express Your Health to provide my medical doctor with a report for my medical record. I also authorize my medical doctor, listed below, and Dr. Wells to discuss my care.

\_\_\_\_\_  
Name of Medical Doctor Office Name

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

\_\_\_\_\_  
Patient Name (Please Print) Patient Signature

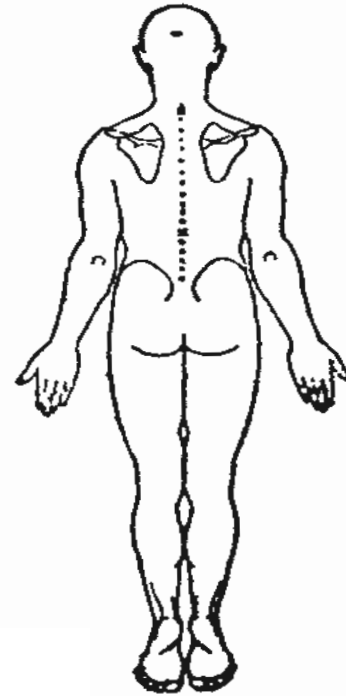
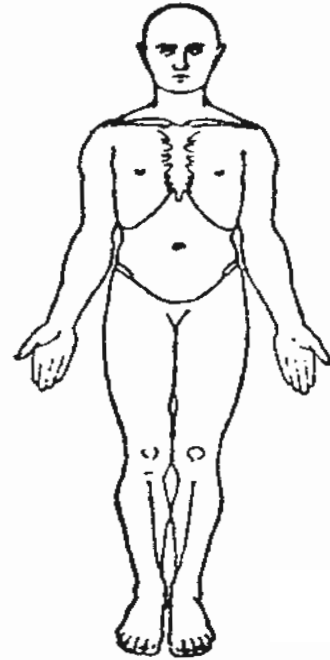
## Tell us about your symptoms:

## Health History Information

- What are your symptoms?  
\_\_\_\_\_
- Is the pain mostly in the back, neck or elsewhere?  
\_\_\_\_\_
- How long ago did these symptoms begin?  
\_\_\_\_\_
- How did they begin? \_\_\_\_\_
- Is the pain constant, or does it come and go?  
\_\_\_\_\_
- How do these symptoms limit you?  
\_\_\_\_\_
- What things make the pain better?  
\_\_\_\_\_
- What makes the pain worse?  
\_\_\_\_\_
- Do you have pain that radiates into the arm or leg?  
\_\_\_\_\_
- Have you lost control of your bowel/ bladder functions?  
\_\_\_\_\_
- Do you have any weakness or numbness/tingling in an arm or leg?  
\_\_\_\_\_
- How long can you: Sit \_\_\_\_ Stand \_\_\_\_ Walk \_\_\_\_
- Is your pain a result of : \_\_\_\_Fall \_\_\_\_ Auto Accident \_\_\_\_ Injury on the job  
Other \_\_\_\_\_
- Have you ever had back/neck problems before this injury?  
\_\_\_\_\_
- Employer at the time of injury: \_\_\_\_\_
- Does your job require lifting, standing or bending?  
\_\_\_\_\_
- Is there a lawsuit pending on this problem? \_\_\_\_No \_\_\_\_Yes
- Who treated you first for this problem?  
Dr. & city \_\_\_\_\_
- What treatments did you have then?  
\_\_\_\_\_
- What test have you had?  
\_\_\_\_\_
- Did you have any injections for your problem? \_\_\_\_No \_\_\_\_Yes
- Did these injections help? \_\_\_\_No \_\_\_\_Yes
- Did you have previous back or neck surgery?  
\_\_\_\_\_
- Have you had physical therapy for this problem?  
\_\_\_\_\_
- Did this therapy help \_\_\_\_No \_\_\_\_Yes
- Do you do any special exercises for your back or neck?  
\_\_\_\_\_
- What do you hope to accomplish today?  
\_\_\_\_\_
- What other concerns do you have?  
\_\_\_\_\_

Draw your pain on the diagrams shown.  
Use the symbols below to show the type of pain you feel.

Stabbing pain	///
Burning pain	ooo
Aching pain	xxx
Pins & Needles	yyy
Numbness	===



Circle your pain level - 1 to 10, 10 being the worst imaginable pain.

1 2 3 4 5 6 7 8 9 10

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. **Serious Injuries:** Describe any significant injuries you have had in your life.

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2. **Past Surgical History**

Have you ever had any problems with anesthesia? \_\_\_No \_\_\_Yes Explain \_\_\_\_\_

Surgery \_\_\_\_\_ Year \_\_\_\_\_ Complications \_\_\_\_\_

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3. **Medical History**

List all past medical problems:

List all current problems:

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Are you currently pregnant or do you think you could be pregnant? \_\_\_\_\_

List all current medications, dosages and frequency: (including over the counter and herbal/supplements):

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What pain medications have you tried in the past? \_\_\_\_\_

4. **List all Drug Allergies** (including adverse reactions):  No known drug allergies

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Latex Allergy \_\_\_Yes \_\_\_No Allergy to X-ray/Contrast dye \_\_\_Yes \_\_\_No

5. **Bleeding:** Do you bleed excessively? \_\_\_Yes \_\_\_No

Do you bruise easily? \_\_\_Yes \_\_\_No

Bleeding disorders in family members? \_\_\_Yes \_\_\_No

6. **Cortisone/Prednisone**

Have you used cortisone or prednisone, by mouth, in the last 12 months? \_\_\_Yes \_\_\_No

7. **Social History**

\_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Separated \_\_\_Widowed

Do you live alone? \_\_\_No \_\_\_Yes Employed? (occupation \_\_\_\_\_) \_\_\_Student \_\_\_Retired

\_\_\_Not working because of back or neck problem Date last worked \_\_\_\_\_

Children? \_\_\_No \_\_\_Yes # \_\_\_\_\_

Exercise? \_\_\_Never \_\_\_Rarely \_\_\_Weekly \_\_\_Daily

What type of exercise? \_\_\_\_\_

Smoker? \_\_\_No \_\_\_Yes \_\_\_Packs per day \_\_\_Years

Quit smoking? \_\_\_No \_\_\_Yes When? \_\_\_\_\_

Previously smoked \_\_\_packs per day for \_\_\_years

Chew tobacco? \_\_\_No \_\_\_Yes How much? \_\_\_\_\_

Drink alcohol? \_\_\_No \_\_\_Yes How much and how often? \_\_\_\_\_

History of substance abuse? \_\_\_No \_\_\_Yes What? \_\_\_\_\_

**8. Review of Systems:**

Are you currently have or have had problems with your:

Circle

Describe all yes responses

- Eyes/Glaucoma No Yes \_\_\_\_\_
- Ears, Nose, Throat, Swallow problems No Yes \_\_\_\_\_
- Lungs, Shortness of breath No Yes \_\_\_\_\_
- Pneumonia No Yes \_\_\_\_\_
- Tuberculosis No Yes \_\_\_\_\_
- Digestion/Ulcers, Acid reflex No Yes \_\_\_\_\_
- Bowel disorders/Blood in stool No Yes \_\_\_\_\_
- Bladder problems No Yes \_\_\_\_\_
- Diabetes/Thyroid No Yes \_\_\_\_\_
- Heart problems/Chest pain No Yes \_\_\_\_\_
- Rheumatic Fever/Heart Murmur No Yes \_\_\_\_\_
- High Blood Pressure No Yes \_\_\_\_\_
- High Cholesterol No Yes \_\_\_\_\_
- Bleeding problems/Blood Clots No Yes \_\_\_\_\_
- Balance problems No Yes \_\_\_\_\_
- Numbness/Tingling No Yes \_\_\_\_\_
- Blackout/Fainting No Yes \_\_\_\_\_
- Stroke/TIA No Yes \_\_\_\_\_
- Psychological problems/ Depression No Yes \_\_\_\_\_
- AIDS/Hepatitis/Jaundice No Yes \_\_\_\_\_
- Cancer No Yes \_\_\_\_\_
- Arthritis/Rheumatoid No Yes \_\_\_\_\_
- Weight Loss or Gain No Yes \_\_\_\_\_
- Epilepsy/Seizures No Yes \_\_\_\_\_
- Migraines or Headaches No Yes \_\_\_\_\_
- Skin Lesions/Rash/Moles No Yes \_\_\_\_\_
- Fever No Yes \_\_\_\_\_
- Night Sweats/Pain worse at night No Yes \_\_\_\_\_

**9. Family History**

Do any of your grandparents, parents, siblings, or children have any of the following diseases? Explain:

- Diabetes No Yes \_\_\_\_\_
- High Blood Pressure No Yes \_\_\_\_\_
- Heart Attack No Yes \_\_\_\_\_
- Cancer No Yes \_\_\_\_\_
- Arthritis No Yes \_\_\_\_\_
- Rheumatoid Arthritis No Yes \_\_\_\_\_
- Back or neck problems No Yes \_\_\_\_\_
- AIDS/HIV No Yes \_\_\_\_\_
- Bleeding disorders No Yes \_\_\_\_\_
- Epilepsy No Yes \_\_\_\_\_
- Hepatitis No Yes \_\_\_\_\_
- Migraines/Headaches No Yes \_\_\_\_\_
- Psychiatric problems No Yes \_\_\_\_\_
- Stomach No Yes \_\_\_\_\_
- Thyroid problems No Yes \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by** \_\_\_\_\_ **Date:** \_\_\_\_\_