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.

Take 2 Healthcare is out of network with all insurance companies and does not file insurance claims. If you wish to file on your own, the information needed for your claim will be found on your receipt of payment.

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 Take 2 Healthcare 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, etc ...)	
_____	_____	_____	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
Do you have a regular thermogram? ___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 Take 2 Healthcare 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.

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