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 we 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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