Northwest Reno Chiropractic New Patient Questionnaire

Patient Information

(Please Print)

Name_____ **Date**_____
Address_____**City**_____ **State**_____**Zip**_____
❑**Male** ❑**Female** ❑**Married** ❑**Single** ❑**Widowed** ❑**Divorced** ❑**Separated**
Birthdate _____ **Cell or Home Phone**_____
E-mail (trying to go as paperless as possible) _____
Employer_____ **Occupation**_____ **#years**_____
Business Address_____**City**_____ **State**_____ **Zip**_____
Spouse or Parent's Name_____ **Phone** _____
Emergency Contact_____ **Phone** _____ **Relation**_____
Whom may we thank for referring you to us? _____
Did you find us: ❑**Insurance book?** ❑**Online?** ❑**Yellow Page Ad?** ❑**Other?** _____
Name of local primary Physician_____ **May we contact them?** _____

Insurance Information – If Insured, please provide copy of insurance card

SYMPTOMS

Main Complaint(s)_____
When did it start?_____ ❑**Getting Worse?** ❑**Getting Better?**
What activity bothers it the most? _____
When is it at its best?_____ **When is it at its worst?**_____
Rate the pain - (0 is pain-free – 10 is unbearable pain) **1 2 3 4 5 6 7 8 9 10**
Other Chiropractors? ❑**Yes** ❑**No** **Positive Experience?**_____
Other type of physician or therapist?_____ **Positive Experience?**_____
Secondary Complaint _____

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other_____			

Women: How many children?_____**Pregnant?**_____**Date of last Menstrual Cycle**_____
Nursing?_____**Taking Birth Control Pills?**_____
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?_____ **Drink 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 and to obtain any information pertaining to my treatment to/from 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 insurance payments may be less than the actual cost of services, and I will be responsible for any outstanding amount owed this office.

Patient Signature:_____ **Date:**_____