SAG CHIROPRACTIC CENTER
Get back to you

PATIENT QUESTIONNAIRE

(PLEASE PRINT)

New Patient ☐
Reactivate ☐
Other ☐

*Full Legal Name _____ *Birth Date _____
First Middle Last

*Address _____ _____ _____ _____
Street / PO Box City State Zip

*Home Phone _____ *Mobile Phone _____ Fax _____

Would you like to receive Email or Text reminders for appointments? ☐ No ☐ Yes – *(*Please sign Authorization form at office)*

*Employer _____ *Work Phone _____ Student ☐ No ☐ Yes - *(see also page 4)*

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Email Address** _____

Spouse Name _____ Phone # _____ Spouse Employer _____

Emergency Contact _____ Phone # _____ Relationship _____

*Did anyone refer you to our office? ☐ No ☐ Yes – Who _____

HISTORY OF PRESENTING ILLNESS/INJURY *(see also page 3)*

*What are your symptoms? _____

*Date your symptoms began? _____

*How did it occur? _____ ☐ *Work Related ☐ *Auto Accident *(*Provide copies of ALL Documents)*

Have you missed any work? ☐ No ☐ Yes - How Much? _____ hours / days / weeks / months

*Do you have any recent X-rays of that area(s)? ☐ No ☐ Yes – Facility where taken? _____

PAST MEDICAL HISTORY *(see also page 4)*

*Have you received care from a Chiropractor before? ☐ No ☐ Yes – Doctor/Clinic _____

INSURANCE COVERAGE *Do you have Insurance? ☐ No ☐ Yes - *Provide COPY of Insurance Card(s)*

CLINIC USE ONLY:

Appointment Date _____ *Time* _____ *am / pm*

Clinic _____ *Provider* _____

Patient Acct # _____ *Staff Initials* _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co _____	Insurance Co _____
Insurance Phone _____	Insurance Phone _____
Policy/Subscriber ID# _____	Policy/Subscriber ID# _____
Group# _____	Group# _____
Policyholder Name _____	Policyholder Name _____
Policyholder Relationship to You _____	Policyholder Relationship to You _____
Policyholder Date of Birth _____	Policyholder Date of Birth _____
Policyholder Employer _____	Policyholder Employer _____

PATIENT DEMOGRAHICS *(*Required per Federal Guidelines)*

SSN# _____-_____-_____

*Gender ☐ Male ☐ Female

*Ethnicity *(select one):* ☐ Hispanic ☐ Not Hispanic

*Race *(select one):*

☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White/Caucasian
☐ American Indian ☐ Black/African American ☐ Other Pacific Islander ☐ Other: _____

*Language *(select one):*

☐ English ☐ Hmong ☐ Lao ☐ Spanish ☐ Vietnamese ☐ Other: _____

*How do you prefer to receive follow-up reminders for Preventive Care? *(select one)* *(see page 1)*

☐ Letter ☐ Phone Call ☐ Email ☐ Fax

*Allergies: ☐ None **-OR-** ☐ See List Below:

Drug/Medication (ADR):	*Food:*	*Other Allergies (e.g.-animals, pollen, latex, etc)*

*Smoking Status (Individuals age 13 years and older):

☐ Smoker-Daily (___Packs/day or ___Cigarettes/day – for: ___Years or Since: _____/_____/_____)
☐ Smoker-Some Days (NOT Daily)
☐ Former (___Packs/day or ___Cigarettes/day – from: Age _____ to Age _____)
☐ Never
☐ Smoker-Current Status Unknown

*Current Prescription Medications ☐ None **- OR -** ☐ See List Below

Name of Prescription:	*Dose (mg, mL, etc)*	*Form (Tab, Caps, etc)*	*Duration (# times per day, wk, mo)*	***-AND-*** *Chronic*	*As Needed*	*Unknown*
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			

CLINIC USE ONLY: ***(Vitals age 2 yrs+)***

Height _____ inches; Weight _____ lbs; Pulse ___ ___ : Respir _____ ; Temp ___ ___ :

Blood Pressure (Left Arm / Right Arm) _____/_____ (Sitting / Standing / Supine) **Staff Initials:** _____

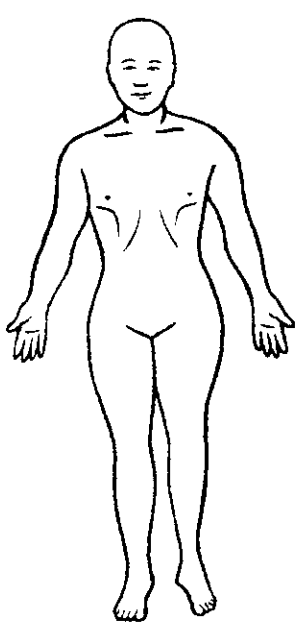
HISTORY OF PRESENT ILLNESS - CHIEF COMPLAINT(S) *(see also page 1)*

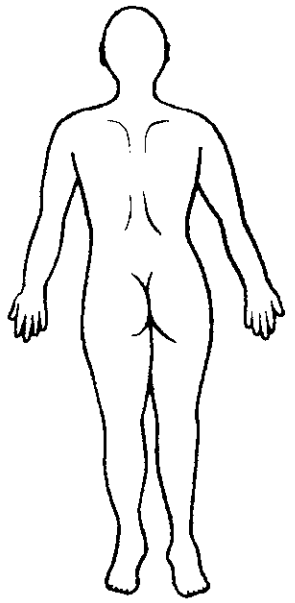
Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Rate your pain on the scale below from 0 to 100 (0 = no pain; 100 = intolerable pain). If there is more than one area of discomfort, please rate the pain 0 to 100 next to each area as appropriate.

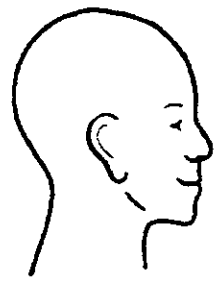
X X X Burning Pain
(((Aching Pain
0 0 0 Pins & Needles
- - - -Numbness
: : : Sharp Pain

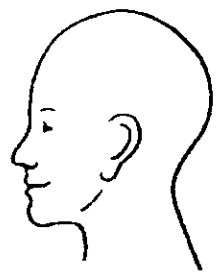
__ Constant
__ Comes/Goes
__ Getting Better
__ Getting Worse
__ Staying Same

Better:	Worse:
__ AM	__
__ MID-DAY	__
__ PM	__









NO PAIN **PAIN SCALE:** **INTOLERABLE**

0 __ 5 __ 10 __ 15 __ 20 __ 25 __ 30 __ 35 __ 40 __ 45 __ 50 __ 55 __ 60 __ 65 __ 70 __ 75 __ 80 __ 85 __ 90 __ 95 __ 100

What Makes Condition BETTER?

Head / Neck:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:
Mid Back:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:
Low Back:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:
Shoulder, Arm, Wrist, Hand:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:
Hip, Leg, Ankle, Foot:	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:
Other: _____	☐ Heat	☐ Cold	☐ Meds	☐ Chiropractic	☐ Other:

What Makes Condition WORSE?

Head / Neck: _____

Mid Back: _____

Low Back: _____

Shoulder, Arm, Wrist, Hand: _____

Hip, Leg, Ankle, Foot: _____

Other: _____

Indicate your Ability to Perform the Following Activities of Daily Living. Please use the following codes:
U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

__ Lying on Back	__ Dressing Self	__ Lifting	__ Kneeling	__ Twist/Turn – LEFT / RIGHT
__ Lying on Sides	__ Stooping	__ Gripping	__ Bending Forward	__ Sitting/Driving/Riding
__ Lying on Stomach	__ Pushing/Pulling	__ Standing	__ Get In/Out of Car	__ Using Computer
__ Turning Over in Bed	__ Reaching	__ Walking	__ Sexual Activity	__ Using Stairs

__ Cough/Sneeze/Grunt – (if painful, where _____)

__ Sleeping - (# times wake up _____ ; # pillows _____; position sleep in: _____)

PAST MEDICAL HISTORY *(see also page 1)*

FEMALES: Are You Pregnant? ☐ No ☐ Yes – Due Date:_____ Doctor: _____

Date of Last Gynecological & Breast Exam: _____

MALES: Date of Last Prostate & Testicular Exam: _____

How often have you had this condition that you are seeing us today for? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Have you received care from a Chiropractor before? ☐ No ☐ Yes *(see also page 1)*

Have you seen a Medical Doctor for this Condition? ☐ No ☐ Yes – Doctor/Clinic _____

Do you have any other Health Conditions? (Check all that apply):

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer

☐ Arthritis ☐ Infertility Issues ☐ Other: _____

Describe any major Illnesses, Injuries, Falls, Hospitalizations, Accidents or Surgeries:

DATE	DOCTOR	CONDITION(S)	RESULTS
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications

SOCIAL HEALTH HISTORY

Student ☐ Part-Time ☐ Full-Time ☐ N/A *(see also page 1)*

Occupation _____ Hrs per Week_____

Recreational Activities/Hobbies_____

Do you Exercise? ☐ No ☐ Yes – How Often? _____ In What Way?_____

Do you consume Caffeine? ☐ No ☐ Yes – How Much? _____ How Often?_____

Do you consume Alcohol? ☐ No ☐ Yes – How Much? _____ How Often?_____

FAMILY HEALTH HISTORY

List any current or past health conditions of your family members (if deceased, indicate at what age and from what?)

MOTHER:_____

FATHER:_____

BROTHERS: _____How Many_____

SISTERS: _____How Many_____

CHILDREN: _____How Many_____

SYSTEM REVIEW QUESTIONS

Have you had any problems with the following areas Now or in the Past? (Y = Yes and N = No)

___**Eyes** (Glasses, Contacts, Cataracts, Glaucoma, Etc)

___**Ears, Mouth, Nose, Throat** (Hearing Loss, Sinus, Etc)

___**Cardiovascular** (Heart, High BP, High Cholesterol, Etc)

___**Respiratory** (Lungs, Breathing, Asthma, COPD, Etc)

___**Neurological** (Nerve Issues, Weakness, Numbness, Etc)

___**Endocrine** (Thyroid, Hormonal, Imbalances, Liver, Etc)

___**Gastro-Intestinal** (Acid Reflux, Ulcers, Gall Bladder, IBS, Etc)

___**Genito-Urinary** (Male/Female Reproductive, Kidney, Bladder, Etc)

___**Musculoskeletal** (Breaks, Arthritis, Osteoporosis, Discs, Etc)

___**Skin** (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, Etc)

___**Psychiatric** (Anxiety, Depression, Bipolar, ADD/ADHD, Etc)

Others: _____

Please describe in more detail: _____

NOTES