CONFIDENTIAL HEALTH QUESTIONNAIRE

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

LAST NAME	FIRST NAME	M.I.	E-MAIL ADDRESS	DATE

ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	ALT. PHONE	DATE OF BIRTH	AGE

EMPLOYER	OCCUPATION	SOCIAL SECURITY NUMBER

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED NO. OF CHILDREN	REFERRED BY:
IN CASE OF EMERGENCY, PLEASE CONTACT:	CONTACT PHONE NUMBER:

Have YOU had CHIROPRACTIC CARE BEFORE? YES or NO *(Please Circle)*
If So: WHERE? HOW LONG AGO?

Do YOU have HEALTH INSURANCE? YES or NO *(Please Circle)*
Company: Policy # Group#

PLEASE INDICATE IF YOU ARE HERE BECAUSE OF AN: ☐Auto Accident ☐ On the Job Injury	IF SO: Date of Injury

COMPLAINT(s)	Type of Pain: Numbness, Tingling, Sharp, Shooting, Ache etc.	Date Started	Intensity 1- No Pain … 10 - Worst
1)			1 2 3 4 5 6 7 8 9 10
2)			1 2 3 4 5 6 7 8 9 10
3)			1 2 3 4 5 6 7 8 9 10

DOES YOUR PROBLEM INTERFER WITH WORK/DAILY ACTIVITIES?	HOW OFTEN DO YOU HAVE YOUR SYMPTOMS?
[ ] Not at all [ ] A little bit [ ] Moderately [ ]Quite a Bit [ ] Extremely	[ ]Constantly (76-100%) [ ]Frequently (51-75%) [ ] Occasionally (26-50%) [ ]Intermittently (1-25%)

WHO ELSE HAVE YOU SEEN FOR THIS CONDITION?	WHAT AGGRAVATES YOUR PROBLEM?	WHAT MAKES YOUR PROBLEM FEEL BETTER?	WHAT CONCERNS YOU MOST ABOUT YOUR PROBLEM/PREVENT YOU FROM DOING?
[ ] Chiropractor [ ] Neurologist [ ] Primary Care Physician [ ] ER Physician [ ] Orthopedist [ ] Massage Therapist [ ]Physical Therapist [ ] Other ________________			
	MONTH/YEAR OF INJURY OR SURGERY	TYPE OF INJURY/SURGERY	DESCRIBE INJURY

PLEASE LIST ANY:	TYPE AND DOSES
PRESCRIBED MEDICATIONS:	
VITAMINS:	
HERBS:	

PLEASE TURN OVER

Past	Present	Past	Present	Past	Present
[ ]	[ ] Headaches	[ ]	[ ] Cancer (type)_______________	[ ]	[ ] Muscular Incoordination
[ ]	[ ] Neck Pain	[ ]	[ ] Asthma	[ ]	[ ] Visual Disturbances
[ ]	[ ] Upper Back Pain	[ ]	[ ] High Blood Pressure	[ ]	[ ] Diabetes
[ ]	[ ] Mid Back Pain	[ ]	[ ] Chest Pains/Angina	[ ]	[ ] Excessive Thirst
[ ]	[ ] Low Back Pain	[ ]	[ ] Stroke	[ ]	[ ] Frequent Urination
[ ]	[ ] Shoulder Pain	[ ]	[ ] Kidney Stones	[ ]	[ ] Dizziness
[ ]	[ ] Elbow/ Upper Arm Pain	[ ]	[ ] Kidney Disorder	[ ]	[ ] Allergies
[ ]	[ ] Wrist Pain	[ ]	[ ] Bladder Infection	[ ]	[ ] Systemic Lupus
[ ]	[ ] Hand Pain	[ ]	[ ] Painful Urination	[ ]	[ ] Depression
[ ]	[ ] Hip Pain	[ ]	[ ] Loss of Bladder Control	[ ]	[ ] Epilepsy
[ ]	[ ] Upper Leg Pain	[ ]	[ ] Prostate Problems	[ ]	[ ] Swollen ankles
[ ]	[ ] Knee Pain	[ ]	[ ] Abnormal Weight Changes	[ ]	[ ] Ringing in Ears
[ ]	[ ] Ankle/ Foot Pain	[ ]	[ ] Loss of Appetite	[ ]	[ ] Sleeping Problems
[ ]	[ ] Jaw Pain	[ ]	[ ] Abdominal Pain	[ ]	[ ] Dermatitis/Eczema
[ ]	[ ] Joint Pain/Stiffness	[ ]	[ ] Ulcer	[ ]	[ ] AIDS/HIV
[ ]	[ ] Arthritis	[ ]	[ ] Hepatitis	[ ]	[ ] Sinus Trouble
[ ]	[ ] Rheumatoid Arthritis	[ ]	[ ] Liver/Gallbladder Disorder	[ ]	[ ] Constipation
[ ]	[ ] Tumor	[ ]	[ ] General Fatigue	[ ]	[ ] Other: _______________

How would you rate your overall health? [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor
What type of Exercise do you do? [ ] Strenuous [ ] Moderate [ ] Light [ ]None
Do you smoke? No or Yes (amount) _______________
Alcohol Intake: _________beer(s) /Liquor / wine **PER** day / week / month / year. ***(Please circle)***

Females: Are you pregnant? Yes No Menstrual Irregularities: Yes No Birth Control Pills: Yes No
Hormone Replacement: Yes No

Please circle if a family member has had any of the following: Heart Disease Diabetes Stroke Cancer
High/Low blood pressure Asthma Gastrointestinal Disease Memory/mood disorder Thyroid problem

Are you interested in finding better health through Nutrition? Yes No Maybe

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The purpose of this office is to provide a form of health care called **Chiropractic** that concerns itself with the true cause of **DIS-EASE**. **The purpose of Chiropractic is to enable the individual to express 100% of his/her potential by removing nervous system interference called subluxations.**

Payment is expected at time of visit. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Kelly Chiropractic, PLLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Kelly Chiropractic, PLLC will be credited to my account on receipt. However, I clearly understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid Kelly Chiropractic, PLLC for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

________________________________ ________________________
Patient's/Guardian's Signature Date

________________________________ ________________________
Signature Authorizing Care Date