Registration/Update and Chiropractic Health Questionnaire Truex Chiropractic Center

Patient Name:_____ **Today's Date:**_____

Home Address:_____**City:**_____**State:**_____ **Zip:**_____

Home Phone:_____ **Cell/Additional Phone:**_____

Date of Birth:_____ **Social Security #:**_____ **E mail :**_____

Employer's Name:_____**Work Phone:**_____

Check One: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced **Any change in Marital Status since last visit?** ☐ Yes ☐ No

Spouse's Name:_____**fp**_____ **Social Security #:**_____

Spouse's Date of Birth:_____ **Employer:**_____ **Cell #:**_____

In Case Of An Emergency Who Should We Contact _____ **Phone #:**_____

1. Please describe your current symptoms _____

_____

2. Date symptoms began _____**Related to** ☐ Work Injury ☐ Auto Accident ☐ None/Other _____

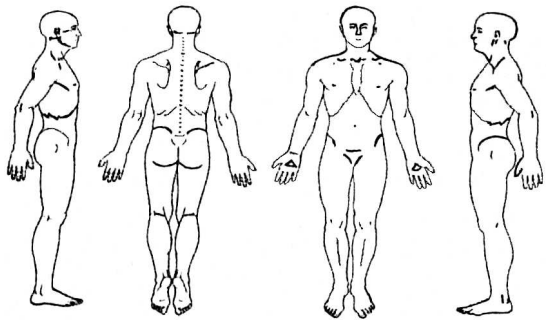
3. Describe how your symptoms began _____

4. How often do you experience your symptoms?
- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

6. What describes the nature of your symptoms?
- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

7. How are your symptoms changing?
- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5 Please Indicate Where You Have Pain or Other Symptoms



None (Check One) Unbearable

8. Indicate the average intensity of your complaints ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

9. What makes your symptoms feel better? _____

10. What makes your symptoms feel worse? _____

11.Who have you seen for your current symptoms? ☐ No one ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist ☐ Other Chiropractor ☐ Other_____

a. Tests performed? ☐ X-rays date: _____ ☐ CT Scan date: _____ ☐ MRI date: _____ ☐ Other date: _____

b. Describe treatment _____

12. Have you had similar symptoms in the past? ☐ No ☐ Yes (explain) _____

_____

Who did you see? ☐ No one ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist ☐ Other Chiropractor ☐ This Office

WHO IS RESPONSIBLE FOR YOUR BILL: ☐ Self ☐ HMO/PPO ☐ Work Comp ☐ Auto Ins. ☐ Medicare ☐ Other_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the this office 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.. I hereby authorize the Doctor to treat my condition, as he deems appropriate through use of Chiropractic adjustments and rehabilitative procedures.

Patient's / Guardian's Signature _____ **Date**_____

OVER PLEASE

Past Health History:

Previous illnesses you've had in your life: _____

_____

Previous injury or trauma? _____

_____

Have you ever broken any bones? Which? _____

Allergies? _____

Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

Social and Occupational History:

Level of Education: O high school O some college O college graduate O post graduate studies

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____