YOUR PRIMARY CARE PROFESSIONAL FOR SPINAL HEALTH AND WELL BEING

PATIENT QUESTIONAIRE: ***Referred by:_____***

Patient Name_____ Today's Date_____

Address_____Town_____Zip_____

Phone Number_____ Email_____

Social Security No:_____Height _____ Weight_____

Date of Birth:_____Age_____ Marital status: Single___ Married___Divorced___Widow___

Occupation_____ Work Number_____

Right handed_____ left handed_____ preferred Language_____

GENERAL INFORMATION RELATED TO YOUR CONDITION:

Approximately when did the condition or symptoms begin to occur?_____

____ No particular condition or symptom--- Just seeking general good health

*Describe the conditions, symptoms or purpose of this appointment*_____

_____

What caused it?_____
*What aggravates it?*_____

What relieves it?_____
Have you ever had the same or similar conditions or symptoms previous to this most recent occurrence
Yes___ No___ When?_____ Describe:_____

Please indicate your Primary Doctor:

Name	*Type of Doctor:*	*Date last visit:*
_____	_____	_____
_____	_____	_____

Please check any of the following symptoms you are now having:

__ Headache __Dizziness __Light Bothers Eyes __Diarrhea __Head seems too heavy __Neck pain

__Loss of Memory __Clumsiness __Feet Cold __Neck Stiff __Tingling in arms/hands __Ears ring

__Hands cold __Sleeping problems __Tingling in legs/feet __Face flushed __Nausea __ Back pain

__ Numbness in arms / hands __Buzzing in ears __Constipation __Nervousness __Numbness in legs

__ Loss of Balance __Cold Sweats __Tension __Short of Breath __Fainting __ Fever __Fatigue

__ Irritability __ Loss of Smell __ Chest pain __Pain in arms / hands __pain in legs/ feet __Jaw pain

__ Loss of strength in arms __Burning muscle pain __Loss of strength in legs __Difficulty to swallow

Other _____

Have you experienced changes in :

___ Eyes ___Ears ___Nose ___Mouth ___Bladder ___Bowels ___Sleep ___Emotions

___Appetite:

*Please explain:*_____

Do you Smoke? Yes ___ No ____ Number of packs per day

*How long have you been smoking*_____

*How long have you quit smoking*_____

*Do You Drink Alcohol? Yes ___ No____ Number of drinks per day*_____

MEDICATIONS

Please list all medication you are now taking (this office will make a copy of all meds.)

_____
_____
_____
_____
_____
_____
_____

SURGERIES/ HOSPITALIZATIONS:

_____
_____
_____

ALLERGIES To Medications and Reactions

_____
_____
_____

DO YOU NOW OR HAVE EVER HAD THE FOLLOWING:

___ Heart Disease ___Diabetes ___Cancer ___Stroke ___ High Blood Pressure ___ Thyroid problem

___Tuberculosis ___Prostate Disorder ___Kidney Problems ___ Asthma ___Ulcer ___seizures

Patient Signature:_____ Date_____

PATIENT CONSENT FORM

Regarding the Use and Disclosure of Protected Health Information

For the purpose of this consent form "Office" shall refer to ; Crawford Chiropractic Center

I understand that some of my health information may be used and / or disclosed by the office to carry out treatment, payment, or healthcare operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled "Our Privacy Practices." I understand that I may review this policy notice at any time prior signing this form.

I understand that over time the Office's privacy practice may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care Corporations and that I can revoke this consent in , but only to the extent that the Office has not taken action in reference thereon and also provided that I do so in writing.

I understand that for my protection, any requests and amend my health information or to access my medical records must be made in writing.

*Please Print Your Full Name;*_____

*Signature:*_____ *Date:*_____

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