# Health Questionnaire

**Please answer all questions to the best of your knowledge, complete and accurate information helps us to provide you with the best possible care.**

**Name:**________________________________________ **Nickname:**__________
First initial Last Suffix

**Address:** ______________________________________________
Street Apt# City State Zip

**Home Phone:** ____________________ **Work/Alternate Phone:**________________

**E-Mail:** ____________________________ **Employer:**_________________________

**Social Security #**_________________ **Date of Birth:** ____________ **Gender: M / F**

**Marital Status:** ___**S** __ **M** ___ **D** ___ **W** **Spouse's Name:** ______________

**If your insurance is through your spouse, parent or guardian, please provide their employer** ________________________________ **and Date of Birth**____________

**How did you hear about our office?**________________________________________

**Is this a Work related Injury?** ________ **Did you have an automobile accident?** ______

**What is your height and weight:** **Height** ___________ **Weight**_____________

**Frequency of exercise:** ___**Never** ___**Rarely** ___**Occasionally** ___ **Moderately** __ **Regularly**

**Intensity of Exercise:** ___**Low Level** ___**Medium Level** ___ **Occasionally** ___ **High Level**

**Sufficient Rest:** ____ **Never** ____**Rarely** ___ **Occasionally** _____ **Moderately**

**Hours of Sleep:** _________

**Well Balanced Diet:** _____**Never** ____**Rarely** ____**Occasionally** _____ **Moderately**

**Do you smoke?** ____**NO** ____**Occasionally** ____ **less than 1 pack per day**
**1 to 2** _____ **2 to 3** _______ **4 to 5** _____ ____ **More than 5 packs/day**

**Do you drink caffeinated beverages?** _____**NO** ______ **Occasionally** ____ **1 to 2**
____**2 to 3** _____ **3 to 4** ____**4 to 5** ____ **More than 5 drinks/ day**

**Do you drink alcoholic beverages?** ____**No** ____ **Occasionally** ____ **1 to 2**
____**2 to 3** _____ **3 to 4** ____**4 to 5** ____ **More than 5 drinks/ day**

**Have you ever used street drugs?** _________**Yes** ______**No**

**Doctor signature**_______________________________________________________

NAME: ______________________ DATE ____/____/______ Account#: ______________

## HISTORY OF ILLNESS / INJURY / PAIN

### LOCATION

Chief complaint and it's location: ______________________________

What caused the onset?: ______________________________

Date of onset?: ____/____/______

### TIMING AND DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent _____Occasional

### SEVERITY

On a scale of 0 to 10, with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None  1 = Minimal  2 = Very mild  3 = Mild  4 = Mild to Moderate  5 = Moderate
6 = Moderate to severe  7 = Mildly severe, restricts some activity  8 = Severe, limits most activity
9 = Very severe  10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

How would you rate your pain on a good day on a scale of 0 to 10?
____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

How would you rate your pain on a bad day on a scale of 0 to 10?
____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

### ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____Inflexibility ____Stiffness ____Spasms ____Cramps

Other: ______________________________

### QUALITY

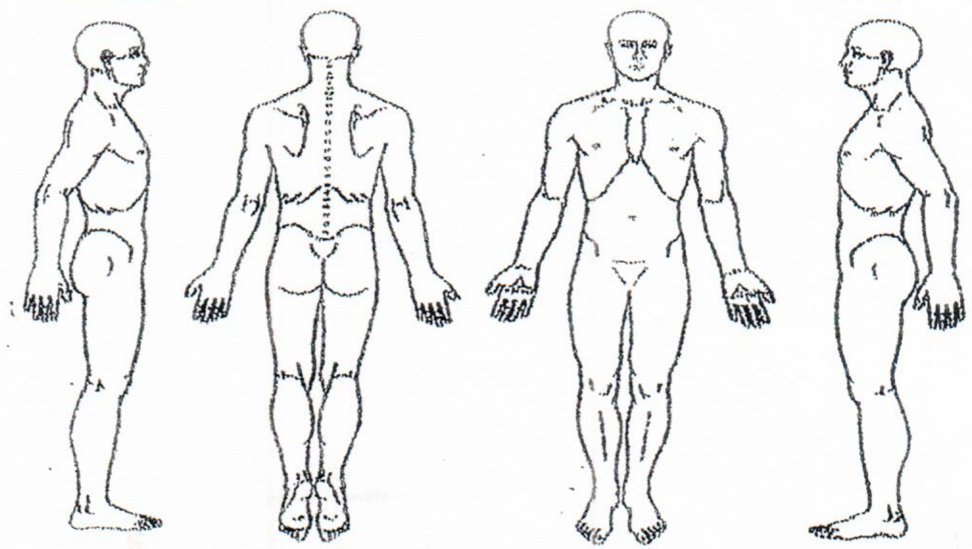
How would you best describe the sensation of the pain/symptom:

| | | | | |
|---|---|---|---|---|
| ____Deadness | ____Prickly | ____Numb | ____Crawling | ____Tingling |
| ____Stabbing | ____Hurting | ____Pulsating | ____Pins & Needles | ____Pounding |
| ____Burning | ____Shooting | ____Throbbing | ____Stinging | |
| ____Dull | ____Sharp | ____Aching | ____Excruciating | |

### ADDITIONAL ASSOCIATED SIGNS & SYMPTOMS

If this pain/symptom radiates or travels, please identify where to: ______________________________

**Please mark where you have pain or other symptoms on the chart**



Doctor Signature ______________________________

Name:________________________________ Date: ____/_____/_____ Account#__________

**Modifying factors**

What aggravates the pain and symptoms?

_____Flashing lights _____Sneezing _____Lifting _____Exercising

_____Stress _____Carrying _____Pushing _____Pulling

_____Coughing _____Sitting _____Stooping _____Looking side/side

_____Looking up/down _____Standing _____Walking _____Climbing stairs

_____Getting out of Bed _____Driving _____Laying down _____Straining at BM

_____Getting in/out of car _____Depression _____Walking up hill / over uneven terrain

Other: ________________________________________________________________

What relieves the pain and symptoms?

_____Resting _____Sleeping _____Cold _____Heat _____Sitting

_____Shower _____Mineral Ice _____Advil _____Aspirin _____Tylenol

______Pain pills _____Exercise/Movement Other: ______________________________

Who have you seen for your symptoms: _______Medical Doctor _______ Other Chiropractor

_______ Physical Therapist ______No One

OTHER: __________________

When and what type of treatment ______________________________________________

Over the past weeks/months your pain and symptoms are:

_____Improving ____Getting Worse _____About the Same

What tests have you have for your symptoms?

MRI: date: ___________ CAT scan date: ___________ X-rays: date: __________

Other: ______________date:_________

Have you had similar symptoms in the past? Y N if yes when? ___________________________

Have you ever been in a car accident or had a work related injury? ____Yes ____No

If yes, please give date(s) and accident type:_____________________________________________

and provide a brief explanation of your injuries:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Name:**_________________________________ **Date:** ____/_____/_____ **Account#**__________

**Medical History:**

**Have you ever been diagnosed with or suffered from:**

____Aids ____Cancer ____Epilepsy ____Multiple Sclerosis ____Tuberculosis

____Anemia ____Diabetes ____Asthma ____Depression ____Alcoholism

____Stroke ____Foot Problems _____Gout _____High Cholesterol

____Heart Disease ____Heart Attack ____Chronic Sinusitis

**Have you ever:** **When?**

| | | |
|---|---|---|
| Been knocked unconscious? | Y N | ____________ |
| Used a Crutch or other support? | Y N | ____________ |
| Been treated for a spine or nerve disorder | Y N | ____________ |
| Had a fractured bone? | Y N | ____________ |

Are you Pregnant? ___Yes ___No Do you think you may be pregnant? ____Yes ____No

Are you now or have you ever taken birth control pills? Y N Year __________

Are you now or have ever been on Hormone replacement therapy? Y N Year _______

Do You Have a Pacemaker? _____Yes ______No

Please list all surgical procedures you have had and times you have been hospitalized (besides Pregnancy):_______________________________________________

_______________________________________________

_______________________________________________

Please list all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:_______________________________________________

_______________________________________________

_______________________________________________

This Patient History was obtained from:
_____Patient ____Mother _____Father ____Son ____Daughter Other: __________

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Signature: ______________________________ Date:____________________

Doctor Signature: ______________________________

Upstate Family Chiropractic, P.C., Dr. Timothy A. Failing D.C
501 West State St., Suite 2
Herkimer, NY 13350

Patient Name: ________________________________

DOB;____________________ SS#:________________________________

**Insurance Info**:

Policy Holder Name:__________________________ Relationship to Patient____________

Policy#:__________________________ Group #__________________

If policy holder is different from patient please provide policy holder's DOB: ________________

**Additional Insurance info, please fill out the information below if you have more than one insurance:**

Policy Holder Name:__________________________ Relationship to Patient____________

Policy#:___________________ Group #__________________

If policy holder is different from patient please provide policy holder's DOB: ________________

**Legal Assignment of Benefits And Release of Medical and Plan Documents:**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Upstate Family Chiropractic, P.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

________________________________ ____________________

Signature of Insured/ Guardian Date

## Acknowledgement of receipt of Notice of Privacy Practices

I Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read, This Notice.

**Signature:** ________________________________

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you.