

# CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

## PATIENT INFORMATION

REFERRED BY: \_\_\_\_\_ Your E-Mail Address (confidential) \_\_\_\_\_

1. LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ 3. MI \_\_\_\_\_

4. ADDRESS \_\_\_\_\_

5. CITY \_\_\_\_\_ 6. STATE \_\_\_\_\_ 7. ZIP \_\_\_\_\_

8. HOME (\_\_\_\_) \_\_\_\_\_ 9. WORK (\_\_\_\_) \_\_\_\_\_ 10. CELL (\_\_\_\_) \_\_\_\_\_

11. AGE \_\_\_\_ 12. DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ 13. SEX  M  F 14. SOC. SEC.# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

14. MARITAL STATUS  S  M  D  W 15. SPOUSE'S NAME \_\_\_\_\_

16. PRIMARY CARE PHYSICIAN: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
TELEPHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

## Employment

1. EMPLOYER & OCCUPATION \_\_\_\_\_

2. ADDRESS \_\_\_\_\_

3. CITY \_\_\_\_\_ 4. STATE \_\_\_\_\_ 5. ZIP \_\_\_\_\_

8. BUSINESS PHONE # (\_\_\_\_) \_\_\_\_\_ 9. FAX # (\_\_\_\_) \_\_\_\_\_

## AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. INSURANCE TYPE:  AUTO  WORK  LIEN  \_\_\_\_\_

2. PATIENT'S RELATIONSHIP TO INSURED:  SELF  SPOUSE  CHILD  \_\_\_\_\_

3. DATE OF INJURY \_\_\_\_\_ 4. DESCRIBE HOW INJURY OCCURED? \_\_\_\_\_

5. **(SCH. LOSS EXAMS)** DO YOU HAVE:  SURGICAL REPORTS  X-RAY REPORTS  MRI REPORTS

6. WHICH BODY PART(S) WERE INJURED? \_\_\_\_\_

7. NAME OF INS. CO. \_\_\_\_\_ 8. INS. PHONE (\_\_\_\_) \_\_\_\_\_

9. INS. CO. ADDRESS \_\_\_\_\_

10. POLICY # \_\_\_\_\_ 11. CLAIM # \_\_\_\_\_ 12. WCB # \_\_\_\_\_

13. DID YOU REPORT INJURY?  NO  YES IF YES, TO WHOM? \_\_\_\_\_

14. HOSPITALIZED?  NO  YES WHERE? \_\_\_\_\_ 15. X-RAYS TAKEN  NO  YES BY WHOM \_\_\_\_\_

16. WHERE YOU WORKING AT THE TIME OF THE ACCIDENT?  NO  YES

17. ARE YOU PRESENTLY WORKING?  NO  YES IF NO, DATES LOST FROM WORK \_\_\_\_\_

18. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY \_\_\_\_\_

19. IF AUTO INJURY, WERE YOU?  DRIVER  PASSENGER  PEDESTRIAN  \_\_\_\_\_

20. # OF PEOPLE IN YOUR VEHICLE? \_\_\_\_ 21. WORE SEAT BELT?  NO  YES 22. DID AIRBAG INFLATE  NO  YES

23. NAME OF ATTORNEY \_\_\_\_\_  
ATTORNEY ADDRESS: \_\_\_\_\_  
ATTORNEY TELEPHONE: (\_\_\_\_) \_\_\_\_\_ ATTORNEY FAX: (\_\_\_\_) \_\_\_\_\_

## PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. INSURED'S NAME \_\_\_\_\_ 2. INSURED'S SS# \_\_\_\_/\_\_\_\_/\_\_\_\_

3. PATIENT'S RELATIONSHIP TO INSURED:  SELF  SPOUSE  CHILD  \_\_\_\_\_

4. NAME OF INSURANCE CO. \_\_\_\_\_

5. ADDRESS \_\_\_\_\_

6. INSURANCE PHONE # (\_\_\_\_) \_\_\_\_\_ 7. POLICY # \_\_\_\_\_

**SECONDARY INSURANCE** 8. INSURED'S NAME \_\_\_\_\_ 9. SS # \_\_\_\_/\_\_\_\_/\_\_\_\_

10. NAME IS INSURANCE CO. \_\_\_\_\_

11. ADDRESS \_\_\_\_\_

12. INSURANCE PHONE # (\_\_\_\_) \_\_\_\_\_ 8. POLICY # \_\_\_\_\_

# CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

## PATIENT HEALTH INFORMATION

1. MAJOR COMPLAINT(S) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. CHECK YOUR PRESENT AND PAST SYMPTOMS

- | PRESENT                  | PAST   |  | PRESENT                  | PAST  |
|--------------------------|--|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> NECK PAIN                             |  | <input type="checkbox"/> | <input type="checkbox"/> EXCESSIVE THIRST           |
| <input type="checkbox"/> | <input type="checkbox"/> MIDDLE BACK PAIN                      |  | <input type="checkbox"/> | <input type="checkbox"/> CHRONIC COUGH              |
| <input type="checkbox"/> | <input type="checkbox"/> LOW BACK PAIN                         |  | <input type="checkbox"/> | <input type="checkbox"/> CHRONIC SINUSITIS          |
| <input type="checkbox"/> | <input type="checkbox"/> HEADACHE                              |  | <input type="checkbox"/> | <input type="checkbox"/> GENERAL FATIGUE            |
| <input type="checkbox"/> | <input type="checkbox"/> DIZZINESS                             |  | <input type="checkbox"/> | <input type="checkbox"/> PAINFUL URINATION          |
| <input type="checkbox"/> | <input type="checkbox"/> CONVULSIONS                           |  | <input type="checkbox"/> | <input type="checkbox"/> FREQUENT URINATION         |
| <input type="checkbox"/> | <input type="checkbox"/> FAINTING, VISUAL DISTURBANCES, NAUSEA |  | <input type="checkbox"/> | <input type="checkbox"/> ABDOMINAL PAIN             |
| <input type="checkbox"/> | <input type="checkbox"/> SHOULDER PAIN                         |  | <input type="checkbox"/> | <input type="checkbox"/> DIFFICULTY IN SWALLOWING   |
| <input type="checkbox"/> | <input type="checkbox"/> PAIN IN UPPER ARMS OR ELBOWS          |  | <input type="checkbox"/> | <input type="checkbox"/> DEPRESSION                 |
| <input type="checkbox"/> | <input type="checkbox"/> HAND PAIN                             |  | <input type="checkbox"/> | <input type="checkbox"/> HIGH BLOOD PRESSURE        |
| <input type="checkbox"/> | <input type="checkbox"/> PAIN IN UPPER LEG OR HIP              |  | <input type="checkbox"/> | <input type="checkbox"/> ANGINA                     |
| <input type="checkbox"/> | <input type="checkbox"/> PAIN IN LOWER LEG OR KNEE             |  | <input type="checkbox"/> | <input type="checkbox"/> HEART ATTACK               |
| <input type="checkbox"/> | <input type="checkbox"/> PAIN IN ANKLE OR FOOT                 |  | <input type="checkbox"/> | <input type="checkbox"/> STROKE                     |
| <input type="checkbox"/> | <input type="checkbox"/> SWELLING/STIFFNESS OF JOINTS          |  | <input type="checkbox"/> | <input type="checkbox"/> ASTHMA                     |
| <input type="checkbox"/> | <input type="checkbox"/> JAW PAIN                              |  | <input type="checkbox"/> | <input type="checkbox"/> CANCER                     |
| <input type="checkbox"/> | <input type="checkbox"/> TINNITUS (EAR NOISES)                 |  | <input type="checkbox"/> | <input type="checkbox"/> EMPHYSEMA (LUNG DISORDERS) |
| <input type="checkbox"/> | <input type="checkbox"/> RAPID HEART BEAT                      |  | <input type="checkbox"/> | <input type="checkbox"/> ARTHRITIS                  |
| <input type="checkbox"/> | <input type="checkbox"/> CHEST PAIN                            |  | <input type="checkbox"/> | <input type="checkbox"/> DIABETES                   |
| <input type="checkbox"/> | <input type="checkbox"/> LOSS OF APPETITE                      |  | <input type="checkbox"/> | <input type="checkbox"/> ULCER                      |
| <input type="checkbox"/> | <input type="checkbox"/> BLOOD DISORDER                        |  | <input type="checkbox"/> | <input type="checkbox"/> BLADDER INFECTION          |
|                          |  |  | <input type="checkbox"/> | <input type="checkbox"/> COLITIS                    |

3. Please describe the character of your current pain:     Sharp/Shooting     Sharp/Dull     Aches     Dull     Soreness  
 Weakness     Throbbing/Gnawing     Numbness     Shooting     Gripping/Constricting     Burning     Tingling

4. Did your problem begin:     Due to an accident     Multiple incidents     Gradually  
 No Specific Reason     Other \_\_\_\_\_

5. Describe how your problem began: \_\_\_\_\_  
 \_\_\_\_\_

6. What treatment have you received for this present condition?     Surgery     Spinal Injections     Physical Therapy  
 Chiropractic     Medicine     X-Ray     Acupuncture     Other \_\_\_\_\_

7. Have you been treated previously for the same condition?     Yes     No  
 If yes, by:     MD     Chiropractor     Physical Therapist     Other \_\_\_\_\_

8. What makes your problem better?     Nothing     Lying Down     Walking     Standing     Sitting  
 Movement/Exercise     Inactivity     Other \_\_\_\_\_

9. What makes your problem worse?     Nothing     Lying Down     Walking     Standing     Sitting  
 Movement/Exercise     Inactivity     Other \_\_\_\_\_

10. Do you work?     Yes     No    If Yes:     Sitting more than 50% of workday     Light Manual labor  
 Manual Labor     Heavy Manual Labor     Other \_\_\_\_\_

# CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

11. Are your complaints affecting your ability to work or otherwise be active?

- No effect      Some physical restrictions (able to perform light duty housework and household tasks)  
 Need limited assistance with everyday tasks.      Need assistance often  
 Have a significant inability to function without assistance.      Cannot care for self.      \_\_\_\_\_

12. Are you currently taking medication?      Yes      No     If yes: \_\_\_\_\_

13. Are you allergic to any drugs or medication?      Yes      No     If yes: \_\_\_\_\_

14. Do you smoke?      Yes      No     How many packs/ Day? \_\_\_\_\_

15. Do you suffer from any type of allergies?      Yes      No     If yes: \_\_\_\_\_

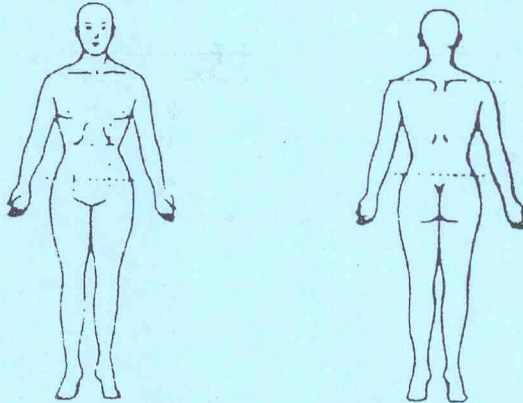
16. Have you had any surgery?      Yes      No     If yes: \_\_\_\_\_

## FAMILY HISTORY

	DIABETES	HEART	KIDNEY	CANCER	BACK	OTHER CONDITIONS
MOTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
FATHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
BROTHER(S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
SISTER(S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

## PAIN / SYMPTOMS PICTURE

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN/SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING.



**I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
PATIENT OR LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

# CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

## ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

PRIVATE & GROUP ACCIDENT & HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to:

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

**A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.**

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

\_\_\_\_\_  
Name of Patient (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Guardian (If Minor)

## MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to \_\_\_\_\_  
Provider Name

for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date