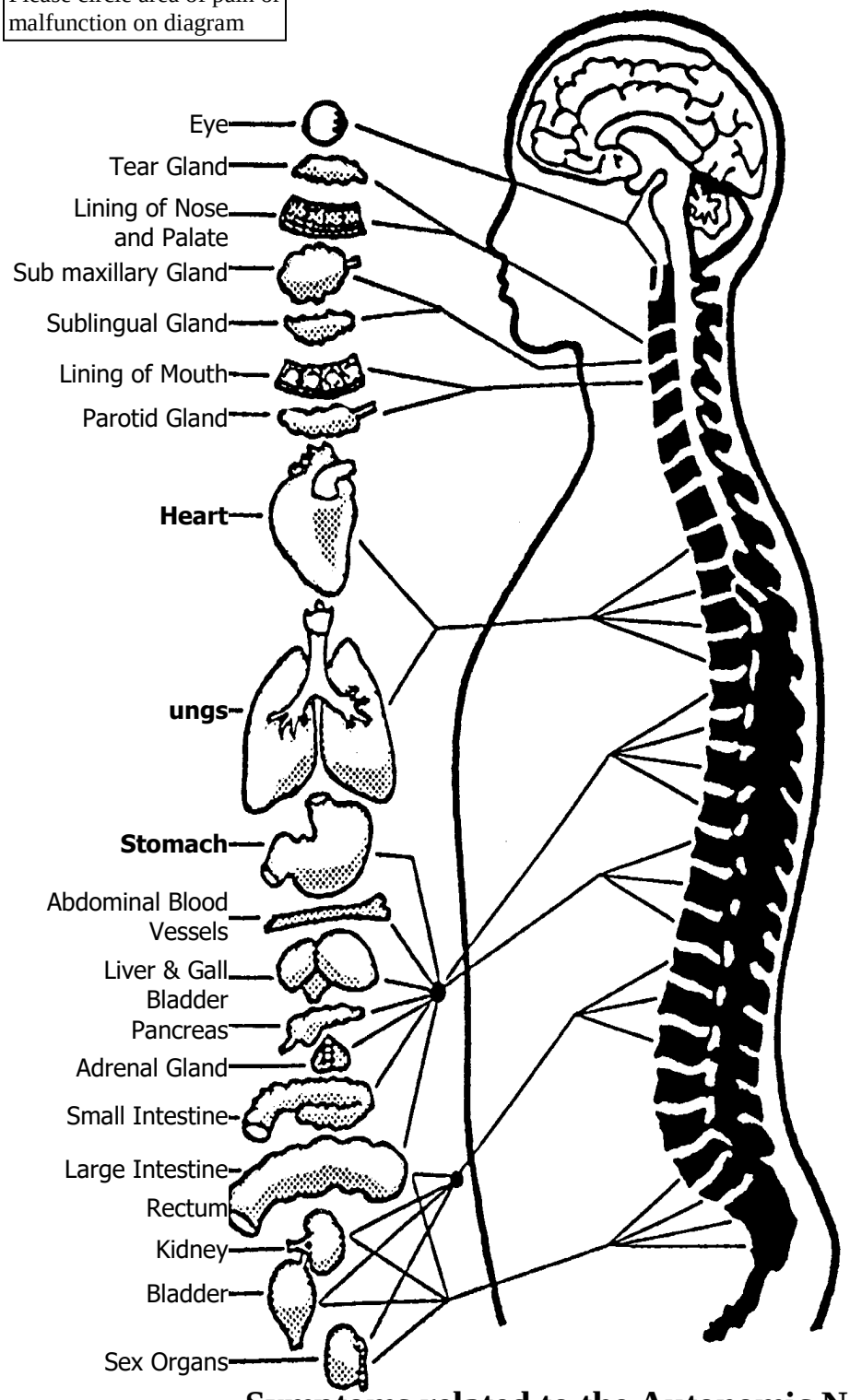
Bullitt Chiropractic, P.A.

Health Questionnaire

Patient's Name

Date

Please circle area of pain or malfunction on diagram



Are you now or have you suffered from any of the following… Check Appropriate Box.

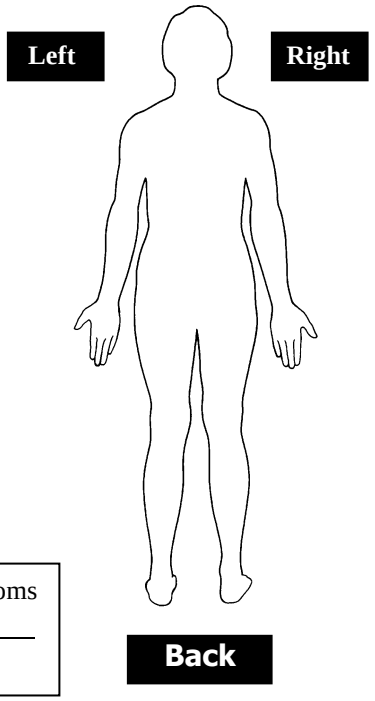
Past	Present	No	
☐	☐	☐	Eye disorders
☐	☐	☐	Loss of Taste
☐	☐	☐	Headaches
☐	☐	☐	Nervousness
☐	☐	☐	Trouble Sleeping
☐	☐	☐	Dizziness
☐	☐	☐	Loss of Smell
☐	☐	☐	Sinus Trouble
☐	☐	☐	Ear Disorders
☐	☐	☐	Frequent Sore Throats
☐	☐	☐	Asthma
☐	☐	☐	Hay Fever/Allergies
☐	☐	☐	Persistent Coughs
☐	☐	☐	Stomach Problems
☐	☐	☐	Rheumatic Fever
☐	☐	☐	Tuberculosis
☐	☐	☐	Heart Disease
☐	☐	☐	High Blood Pressure
☐	☐	☐	Diabetes
☐	☐	☐	Poor Digestion
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Abdominal Pains
☐	☐	☐	Hemorrhoids
☐	☐	☐	Urinary Disorders
☐	☐	☐	Bed Wetting
☐	☐	☐	Menstrual Disorders
☐	☐	☐	Sex Problems
☐	☐	☐	Tension
☐	☐	☐	Irritability
☐	☐	☐	Fatigue

Symptoms related to the Autonomic Nervous System

Chiropractic deals with the relationship between your spine and nervous system.
The Nervous System's function is to control and coordinate all these organs and structures.
Pinched or irritated nerves may interfere with the function and thus cause a wide variety of symptoms.

Symptoms that can be related to Spinal Nerves

Please mark area of pain on diagram.



Past	Present	No		Past	Present	No	
☐	☐	☐	Scalp Disorders	☐	☐	☐	Low Back Pain
☐	☐	☐	Head Pain or Headaches	☐	☐	☐	Low Back Pain
☐	☐	☐	Neck Pain	☐	☐	☐	Low Back Weakness
☐	☐	☐	Shoulder Pain or Stiffness	☐	☐	☐	Low Back Stiffness
☐	☐	☐	Arm Pain	☐	☐	☐	Hip Pain or Stiffness
☐	☐	☐	Tennis Elbow	☐	☐	☐	Buttock Pain
☐	☐	☐	Loss of Arm Power	☐	☐	☐	Leg Cramps
☐	☐	☐	Loss of Grip	☐	☐	☐	Tingling, Numbness, or Pain in Leg
☐	☐	☐	Tingling, Numbness, or Pain in Hand	☐	☐	☐	Knee Trouble
☐	☐	☐	Mid-Back Pain	☐	☐	☐	Foot Trouble
☐	☐	☐	Mid-Back Tension	☐	☐	☐	Tingling, Numbness, or Pain in Foot
☐	☐	☐	Pain in Ribs				

No Symptoms Extreme Symptoms

_____

Please place an "X" on the line above to indicate your level of PAIN.

Family History

	Father	Mother	Siblings	Grandparents	Children
Cancer	☐	☐	☐	☐	☐ ☐
Heart Disease	☐	☐	☐	☐	☐ ☐
High Cholesterol	☐	☐	☐	☐	☐ ☐
Stroke	☐	☐	☐	☐	☐ ☐
Aneurysm	☐	☐	☐	☐	☐ ☐
Alcohol Use	☐	☐	☐	☐	☐ ☐
Tobacco Use	☐	☐	☐	☐	☐ ☐
Drug Use	☐	☐	☐	☐	☐ ☐
Diabetes	☐	☐	☐	☐	☐ ☐
Osteoporosis	☐	☐	☐	☐	☐ ☐
Family Members Still Alive	☐	☐	☐	☐	☐ ☐
Other Hereditary Disorders	☐	☐	☐	☐	☐ ☐

How many children do you have? _____

What are their current ages? _____

Personal Habits

Type	**Amount**	**Per ***
Exercise		
Dairy Products		
Soda Pop		
Coffee/Tea		
Alcoholic Beverages		
Tobacco (any type)		
Drugs (any type)		
Vitamins		

* Please write Day, Week, or Month as applicable.

Occupation

What is your trade?_____

Does your job require you to:

☐ Sit ☐ Stand ☐ Bend ☐ Walk ☐ Lift

How much of each?_____

_____

Dr. Notes:_____

_____

_____

_____

_____

Printed Name_____ Date_____

BULLITT CHIROPRACTIC, P.A.
PATIENT CONDITION INFORMATION

Main complaint and symptoms: _____

Describe the pain: ☐ Sharp ☐ Dull ☐ Tightness ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

Does the pain radiate into your arms or legs? ☐ yes ☐ no Which? _____

How frequent is the condition? ☐Constant ☐ Intermittent ☐ Daily ☐Night only

How long does it last? ☐ All Day ☐ A Few Hours ☐ A Few Minutes

When did you first notice this problem? _____

Has your condition ☐ improved ☐ gotten worse or ☐ stayed the same since its onset?

Was your condition ☐ caused or ☐ aggravated by and accident? ☐ yes ☐ no. **Date of Injury** _____

If your above answer is yes, please check the type of accident? ☐ Auto ☐ On Job ☐ Other

Describe the Accident _____

_____

What makes your condition worse? ☐ Sitting ☐ Standing ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐ Other_____

Does anything make it feel better? _____

Have you had any previous treatment for this or similar conditions? ☐ yes ☐ no

When?_____Treated how long?_____ Who treated you? _____

Results?_____

Have you been under previous chiropractic care? ☐ yes ☐ no Who? _____

List and describe the nature of any Surgery, Trauma, Injury, or Medications: _____

_____

_____

Women: Is there any possibility that your pregnant? ☐ yes ☐ no Date of Last Menstrual Period:_____

INFORMED CONSENT

Informed consent is more than just a signed document. The following categories will be or have been discussed.

- What's wrong? or your diagnosis.
- What tests will be ordered; the reason for them; and results expected to achieve.
- Whether or not Chiropractic can be helpful in this case.
- Alternative treatments and your options.
- A treatment plan outlined for your case with expected time frame for results.
- Cost of this Treatment.

These categories have been discussed with me in my report of findings; and I am authorizing the doctor to treat my conditions within the parameters outlined, to the best of his ability.

PATIENT'S SIGNATURE_____ **DATE:** _____

Patient's Printed Name _____

BULLITT CHIROPRACTIC, P.A.

PATIENT INFORMATION

NOTE: PLEASE COMPLETE THIS FORM WITH YOUR SIGNATURE AT THE BOTTOM OF THE PAGE

Patient's Name: _____ Nickname: _____

Address: _____

Email Address: _____ Cell Phone & Carrier: _____

Birth Date:_____ Sex: ☐ M ☐ F Marital Status: ☐M ☐S ☐W ☐D

Employer:_____Occupation: _____

Spouse's Name: _____Spouse's Date of Birth: _____

Name and Age of Children: _____

Name of your physician:_____ Would you like a report sent to him/her? ☐yes ☐ no Phone # _____

Name and number of Nearest Relative not living with you _____ Phone # _____

Who or What Referred you to the office of BULLITT CHIROPRACTIC? _____

INSURANCE INFORMATION*

**Please complete this section in full if you are covered by insurance or are entitled to receive benefit payments.*

This information will assist us in helping you obtain the benefits in which you may be entitled.

Name of Insurance Company_____

Address_____

Name of Primary Insured: _____ Insured's Birth Date: _____

Insured's Employer: _____Type: ☐ Group ☐ Private ☐ Workman's Comp ☐ Automobile

Policy# _____ Group# _____ Membership Phone # _____

PATIENT CERTIFICATION AND SIGNATURE

I, the patient, certify that the above information is true and correct. I hereby authorize the release of any information required to secure payment for services rendered. I also authorize and direct that any insurance or medical coverage benefit payments to which I may be entitled shall be paid directly to **Bullitt Chiropractic, P.A.**
I understand and agree that I am financially responsible for and will promptly pay any non-covered services including, but not limited to, deductible and copay.

I, the patient, understand and agree to allow this chiropractic office to use their Patient Health information for the purpose of treatment, payment, healthcare operations, and coordination of care.

PATIENT'S SIGNATURE_____DATE:_____

We, at Bullitt Chiropractic, want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT'S SIGNATURE_____DATE:_____