

## NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient File #: \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**WELCOME:** The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

**INSTRUCTIONS:** Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

**PERSONAL INFORMATION:**

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Jr., II, III, IV  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Marital Status (Circle): Divorced Married Single Separated Widowed  
 Gender (Circle): Male / Female Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_ @ \_\_\_\_\_  
 Spouses Name: \_\_\_\_\_ Names & Ages of Children: \_\_\_\_\_  
 Is your spouse a patient in our office?  Yes  No

**Employer /Employment Status**  Employed  Unemployed  Full Time /  Part Time Student  Other

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type of Work: \_\_\_\_\_

Is it ok to contact you at work?  Yes  No

**Emergency Contact Information**

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Jr., II, III, IV

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PAYMENT/INSURANCE INFORMATION:**

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

Yes  No

Who besides yourself is responsible for your bill?  Self-Pay  Health Insurance

Medicare  Medicaid  Worker's Comp

Auto Insurance  Other (Be Specific): \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_

Insured Person's Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Person's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured Person's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Auto or Workers' Comp Insurance Carrier & Claim #: \_\_\_\_\_

**PRIMARY COMPLAINT:**

When did it start? \_\_\_\_\_  
Describe the condition: \_\_\_\_\_  
What do you think caused the problem? \_\_\_\_\_  
Rate the pain from 1-10: At it's worst \_\_\_\_\_ At the present time \_\_\_\_\_ At least severe \_\_\_\_\_  
Does the pain travel?  Yes  No If yes, from where to where? \_\_\_\_\_  
Is condition getting worse?  Yes  No  
List the activities that this condition prevents you from doing? \_\_\_\_\_  
List past treatment for this condition and if they helped \_\_\_\_\_

**SECOND COMPLAINT:**

When did it start? \_\_\_\_\_  
Describe the condition: \_\_\_\_\_  
What do you think caused the problem? \_\_\_\_\_  
Rate the pain from 1-10: At it's worst \_\_\_\_\_ At the present time \_\_\_\_\_ At least severe \_\_\_\_\_  
Does the pain travel?  Yes  No If yes, from where to where? \_\_\_\_\_  
Is condition getting worse?  Yes  No  
List the activities that this condition prevents you from doing? \_\_\_\_\_  
List past treatment for this condition and if they helped \_\_\_\_\_

**THIRD COMPLAINT:**

When did it start? \_\_\_\_\_  
Describe the condition: \_\_\_\_\_  
What do you think caused the problem? \_\_\_\_\_  
Rate the pain from 1-10: At it's worst \_\_\_\_\_ At the present time \_\_\_\_\_ At least severe \_\_\_\_\_  
Does the pain travel?  Yes  No If yes, from where to where? \_\_\_\_\_  
Is condition getting worse?  Yes  No  
List the activities that this condition prevents you from doing? \_\_\_\_\_  
List past treatment for this condition and if they helped \_\_\_\_\_

**LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:**

\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
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**LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:**

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Is there any other information that you feel would be relevant to your current condition(s) that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor.

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**AUTHORIZATION FOR RELEASE OF INFORMATION:**

I authorize the release of any medical information necessary to process my insurance claims.

**AUTHORIZATION OF ASSIGNMENT:**

I authorize payment of medical benefits to \_\_\_\_\_ for services rendered to me.

**REIMBURSEMENT POLICY:**

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

**ACCEPTANCE AS A PATIENT:**

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

\_\_\_\_\_  
**PATIENT PRINTED NAME**

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

## Personal Injury Questionnaire

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Nature of Accident: ( ) Car Crash ( ) slip/fall ( ) Other \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_ Were you ( ) Driver ( ) Passenger Front ( ) Back Seat

In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_

What city did the accident take place in? \_\_\_\_\_ Were you struck from ( ) Behind ( ) Front ( ) Left Side ( ) Right side

Make, model, and year of your vehicle \_\_\_\_\_ Make, model, and year of the other vehicle \_\_\_\_\_

Approximate speed of your vehicle \_\_\_\_\_ mph. Approximate speed of the other vehicle \_\_\_\_\_ mph.

Is the damage to your vehicle ( ) mild ( ) moderate ( ) severe Is the damage to the other vehicle ( ) mild ( ) moderate ( ) severe

Did your vehicle have a trailer hitch? ( ) YES ( ) NO Were you wearing seat belt? ( ) YES ( ) NO

Did your airbag deploy? ( ) YES ( ) NO Did the airbag deploy in the other vehicle? ( ) YES ( ) NO ( ) UNKNOWN

Did you hit your head? ( ) YES ( ) NO Were you knocked unconscious? ( ) YES ( ) NO Is your car drivable? ( ) YES ( ) NO

In what direction were you looking at the time of impact? \_\_\_\_\_ Did you brace for impact? ( ) YES ( ) NO

Was your car towed? ( ) YES ( ) NO Was the other car towed? ( ) YES ( ) NO Did You go to ER by Ambulance? ( ) YES ( ) NO

Is there a police report? ( ) YES ( ) NO Do you have pictures of the vehicles involved? ( ) YES ( ) NO

Did the ER take X-rays? ( ) YES ( ) NO MRI ? ( ) YES ( ) NO CT ? ( ) YES ( ) NO MEDS? \_\_\_\_\_

Where did you hurt immediately following the impact? \_\_\_\_\_

List all the areas that are hurting you now. \_\_\_\_\_  
\_\_\_\_\_

Any prior history or treatment of similar complaints? \_\_\_\_\_

Any prior auto accidents? ( ) YES ( ) NO if so, when? \_\_\_\_\_

What treatment have you received so far? \_\_\_\_\_

Who is your attorney? \_\_\_\_\_ Do You have MED PAY? ( ) YES ( ) NO ( ) UNKNOWN

Number of people in your vehicle \_\_\_\_\_ Did YOU receive a citation? ( ) YES ( ) NO Time of Day \_\_\_\_\_

Did the OTHER DRIVER receive a citation? ( ) YES ( ) NO Road Conditions ( ) Dry ( ) Damp ( ) Wet ( ) Snow ( ) Icy

Describe the damage to your vehicle? \_\_\_\_\_

Number of cars involved in accident? \_\_\_\_\_ Did you lose any time from work? \_\_\_\_\_

Please send pictures of crash and injuries to [mccrackenchiro@yahoo.com](mailto:mccrackenchiro@yahoo.com) (VERY IMPORTANT!!!)