BRIGHTON
SPINE AND WELLNESS
CHIROPRACTIC - NUTRITION - REHABILITATION

PATIENT HEALTH QUESTIONNAIRE

PERSONAL INFORMATION

Today's Date:_____/_____/_____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____-_____-_____ Work: _____-_____-_____ext._____

Cell: _____-_____-_____ Email:_____

Emergency Contact: _____ Phone: _____-_____-_____

Occupation:_____ Employer: _____

Marital Status: S M D W Sex: M F Name of Spouse: _____

Who referred you to our office or how did you hear about us?_____

Have You Had Previous Chiropractic Care? ☐ No ☐ Yes

Health Insurance Information: _____

PATIENT COMPLAINTS

Pain Drawing: Please mark where and what type of pain you are currently experiencing:

Symptoms developed from: ☐ Work Injury ☐ Car Accident ☐ Sports Injury ☐ Repetitive Stress ☐ Unknown

Date of injury _____ Date Symptoms Began _____

Please Describe:_____

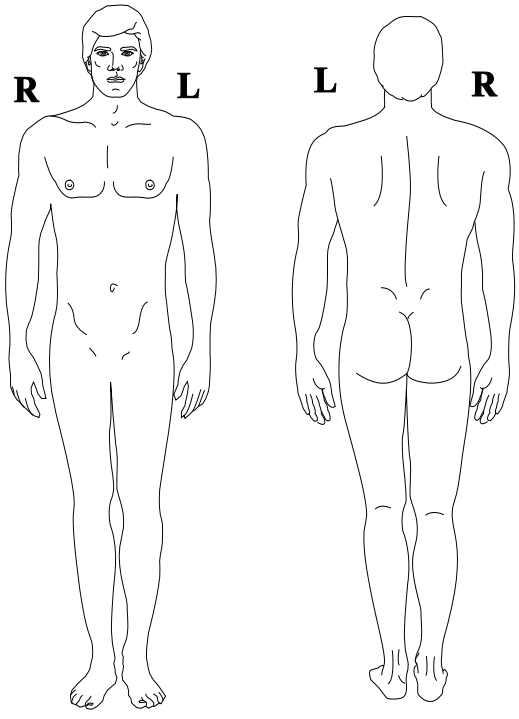
_____

_____

_____

_____

_____



Mark area of pain with an X and rate 1 – 10 See scale below)

1	2	3	4	5	6	7	8	9	10
	MILD			**MODERATE**				**SEVERE**	

PATIENT COMPLAINTS *(continued)*

Check off the symptoms / problem areas you have experienced in the past 6 months:

☐ Neck Pain	☐ Disc Problems	☐ Digestive Problems	☐ Fibromyalgia
☐ Headaches/Migraines	☐ Scoliosis	☐ Hip, Knee, or Foot Pain	☐ Dizziness
☐ Shoulder Paina	☐ Arthritis Pain	☐ Stress/Fatigue	☐ Numbness/Tingling
☐ Lower Back Pain	☐ Jaw Pain/TMJ	☐ Ringing in Ears	☐ Nervousness/Anxiety
☐ Sciatica	☐ Whiplash Injuries	☐ Carpal Tunnel Syndrome	☐ Asthma

LIFESTYLE HISTORY

On a scale of 1 – 10 how would you rate your daily stress level: _____

Where in your body do you carry stress? _____

What tools have you used to try and reduce your stress? _____

Do you exercise, meditate, or practice yoga? Please describe: _____

_____

Do you have good posture? ☐ No ☐ Yes

Please describe: _____

Do you have trouble going to sleep or staying asleep? ☐ No ☐ Yes

What is your sleeping position? ☐ Stomach ☐ Back ☐ Side

How old is your mattress? _____ How many pillows do you sleep on? _____

How many cups of coffee or caffeinated drinks do you have per day? _____

Do you have extra belly fat? ☐ No ☐ Yes

Do you have sugar or carbohydrate cravings? ☐ No ☐ Yes

Have you heard from your doctor that you have any of the following:

☐ Elevated Blood Pressure ☐ Elevated Cholestorol or Triglycerides ☐ Elevated Blood Sugar

Are you taking prescription medications? ☐ No ☐ Yes

Please describe: _____

Are you taking vitamins or supplements? ☐ No ☐ Yes

Please describe: _____

On a scale of 1 – 10, indicate what level of importance you give to improving your overall health:

1	2	3	4	5	6	7	8	9	10

LEAST IMPORTANT **MOST IMPORTANT**

MEDICAL HISTORY

Please list any serious illness or medical conditions you have had and associated treatment:

_____

_____

_____

Please list the name and address of your primary care physician & any specialist you have seen:

_____

_____

SURGICAL HISTORY

Please list any surgeries you have had; include date, type of surgery or for what condition and outcome:

_____

_____

FAMILY HISTORY

Please list any family history of heart disease, cancer, diabetes or other serious illness:

_____

_____

_____

HEALTH INSURANCE INFORMATION

Name of Insured_____

Name of Insurance Co. _____

Address _____

Policy # _____ Telephone # _____

Spouse Insurance Co. _____

Address _____

Policy # _____ Telephone # _____

Payment Is Expected at Time of Visit Unless Other Arrangements Are Made

Name of Person responsible for payment _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the release of any and all information you deem appropriate concerning my physical condition and treatment to any insurance company, attorney or adjuster in order to process claims for reimbursement of chiropractic charges incurred by me. I give my chiropractor power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree any services rendered to me are charged directly to me and that I am personally responsible for payment; including those resulting from my failure to obtain a necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original. I hereby irrevocably authorize the direct payment from the insurance company to my chiropractor any sum I now or hereafter owe for my chiropractic treatment. I understand and agree a credit history may be initiated by my chiropractor to determine my credit worthiness and/or if I am delinquent in paying my bill. I agree to pay all attorney fees incurred by my chiropractor in the collection of any account balance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____/_____/_____

Guardian or Spouse's Signature _____Date: _____/_____/_____