Haydel
CHIROPRACTIC

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www.HealthPROwellness.com

~Preliminary Information Questionnaire~

Date:____/____/____ Referred By:_____

Patient's Full Name_____ Age____

Address_____ Single____ Married____

City_____ State____ Zip____

Phone_____ Cell_____ Date of Birth____/____/____

Social Security #_____ Drivers License #_____

Employer_____ Occupation_____

Business Address_____ Phone#_____

Name of Parent/Spouse_____

Phone (If Different)_____ Cell_____

Spouse Employer_____ Phone_____

Spouse/Parent Social Security #_____

~Responsible Party Information~

Type of Insurance: (please check one) ☐ Self ☐ Medical ☐ Auto ☐ Workers Comp ☐ Attorney

Name_____ Phone_____

Address_____ City_____ State____ Zip____

Policy#_____ Group#_____

Claim#_____ Adjuster Name:_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____.
Name of Insurance Company

And assign directly to _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this facility/provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Responsible Party Signature Date

~Health Questionnaire~

Patient name:_____ Date:_____

What are your main problems/pains?_____

Have you seen another Physician for this problem? (Y) (N) Whom?_____

Date of Accident/Beginning of Illness_____Location of Accident _____

☐ Auto ☐ On the Job ☐ Other Describe circumstances of accident/injury_____

_____

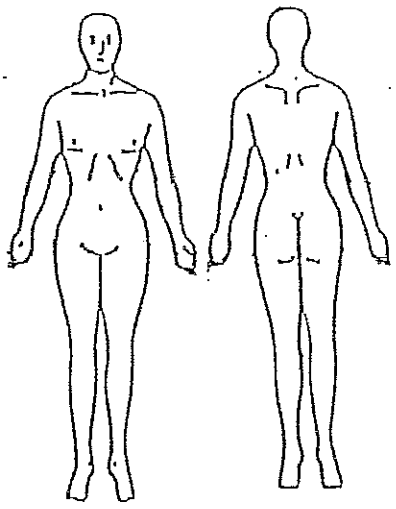
Have you ever had the same or similar injury before? (Y) (N) If yes, please explain & give dates:_____

Have you lost time from work? (Y) (N) Give Dates_____

Are you Pregnant? (Y) (N) Number & Age of Children_____

****Please check any of the following symptoms that you have experienced or are currently experiencing****

MUSCULO-SKELETAL SYSTEM
- ☐ Low Back Problems
- ☐ Pain between Shoulders
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ Ruptures
- ☐ Broken Bones
- ☐ Numbness

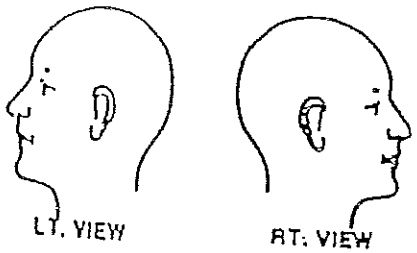


~PLEASE COLOR IN AREAS OF PAIN~

GENITO-URINARY SYSTEM
- ☐ Bladder Trouble
- ☐ Excessive Urination
- ☐ Scanty Urination
- ☐ Painful Urination
- ☐ Discolored Urination

EAR, NOSE AND THROAT
- ☐ Eye Strain
- ☐ Eye Inflammation
- ☐ Vision Problems
- ☐ Ear Pain
- ☐ Ear Noises
- ☐ Nose Bleeding
- ☐ Nose Discharge

CARDO-VASCULAR/RESPIRATORY
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Rapid Heart Beat
- ☐ Blood Pressure Problems
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Varicose Veins



NERVOUS SYSTEM
- ☐ Liver Trouble
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle Jerking
- ☐ Convulsions
- ☐ Depression

Childhood Diseases:_____

Complication:_____

Prior Surgery:_____

Medications Presently Taking:_____

Previous Accidents:_____