Nadeau Chiropractic
& WELLNESS CENTER

Health Questionnaire

Fill out all pertinent Information

1. Name:_____Date:_____
2. Home Address:_____City:_____State:____ Zip:_____
3. Telephone: Home: ( )_____ Cell: ( )_____ Work: ( )_____
4. Email Address:_____
5. Employer: _____
   (name) (address) (zip)
6. Social Sec #: _____ Birth Date:____/____/_____ Age:_____ Sex: M/F
7. Circle One: M S W D Children, Ages:_____ Referred by:_____
8. Guardian or Spouse's Name: _____
9. Guardian or Spouse's Employer: _____
10. Number of years completed: elementary school _____ high school _____ college _____
11. Insurance Company :_____
12. Policy Holder: _____Relationship:_____ Date of Birth _____
13. Insurance ID Number: _____
14. Date injury or illness began: _____ How _____ Date last worked _____
15. List other doctors consulted for this problem: _____
    A. Chiropractic/Osteopathic History: Have you had manipulative therapy in the past: Yes/No
    If Yes, when & why? Were the results positive?: _____
16. Is your condition related to a work related accident or an automobile accident: Y/N
    Employer Notified: Y/N If yes, who or what department: _____
    Automobile Insurance notified: Y/N Adjusters Name _____
    Date of Accident _____ Time _____ AM _____ PM _____
    Injured at: Address _____ City _____ State _____ Zip: _____
17. In general, what type of healthcare is desired: □ emergency □ relief □ corrective □ maintenance □ preventative □ prefer doctor to select type of care he feels is best for me □ nutrition – general □ nutrition – comprehensive
18. List below in order of importance, your chief complaints and what makes them feel better and/or worse and preventative/wellness interests that you would like help with:
    A._____ B._____
    C._____ D._____

SURGERY/TRAUMA

Fill in your approximate age next to any surgical procedure or traumatic accident you have had, extra space is available for non-listed items and further comments.

Tonsils/adenoids _____
Appendix _____
Gall Bladder _____
Hernia – Inguinal _____
Hernia – Umbilical _____
Hemorrhoids/ varicose veins _____
Hysterectomy _____
Ovary L _____ R _____
Disc Removal – Cervical _____
Disc Removal – Lumbar _____
With Fusion _____
Wisdom teeth _____
Impacted Y/N _____
Any other surgeries Y/N _____
Fractures – What & When _____
_____
Strains/Sprains, dislocations (accidents) – list all car, motorcycle, or other traumatic accidents giving approximate age and description of injuries sustained:_____
_____

DENTAL HISTORY

Do you have all of your own teeth? Y/N _____
If no, describe _____
If yes, approximate number of fillings _____
Type □ amalgam □ gold
Have you had any dental surgery Y/N
Describe _____
Recurrent problems with:
Cold Sores Y/N _____
Canker Sores Y/N _____
Cracks in the corners of your mouth Y/N _____
Sun/Fever blisters Y/N _____
Herpes Y/N _____
Bleeding Gums Y/N _____
Coated Tongue Y/N _____
Other dental procedures done (e.g. root canal, gum resection, orthodontic appliances) _____
_____
_____

X-RAYS

If you have had any of the following and approximate dates:
Dental _____
Low Back _____
Neck _____
Chest _____
Head _____
Gall Bladder _____
Upper GI _____ Lower GI _____
CAT Scan _____ MRI _____
Extremities _____

LAB WORK

Give approximate date of latest blood work:
What was done_____
Where _____
Blood Count _____
Urinalysis _____
Complete work up _____
EEG _____
Other _____
Any abnormal findings _____

SYSTEMS REVIEW

Check if you have had the following in the past. Star if you have now or within the past 3 months, also circle the appropriate choice.

Dizziness _____
Fainting Spells _____
Middle Ear Infections _____
External Ear Infections _____
Ear Wax _____
Tinnitus (ringing of the ear) _____
Impaired Hearing _____
Ear Injury L/R _____
Clicking/Popping Jaw L/R _____
Pain in Jaw, Locking Jaw L/R _____
Clenching, bruxing _____
Eye injury/disease _____
Impaired sight _____
Glasses _____
Near/Far sighted _____
Poor night vision _____
Astigmatism _____
Scalp dry/oily _____
Hair brittle/dry _____
Saliva wet/dry _____
Sinus Congestion Y/N _____
Nosebleeds Y/N _____
Headaches Y/N Front _____ Back _____ Side L/R_____
Time of day A.M. _____ Noon _____ P.M. _____
Intensity: Mild ___ Moderate ____ Severe _____
Duration Hours _____ Days _____ Years _____
Relieved by aspirin? Y/N
Other _____

NECK

Neck stiffness/pain Y/N L/R _____
Enlarged glands Y/N _____
Difficulty swallowing Y/N _____
Sore throats Y/N _____ Swollen tonsils Y/N_____
Frequent colds Y/N_____
Thyroid – overactive ___ underactive _____ enlarged _____
Goiter Y/N _____
Other _____

SHOULDERS/ARMS/HANDS

Pain between shoulders Y/N _____
Pain in shoulders L/R _____
Pain in arms L/R _____
Pain in elbow L/R _____
Pain in forearm L/R _____
Pain in wrist L/R _____ Pain in hand L/R _____
Loss of grip strength L/R _____
Numbness/tingling in hands, fingers L/R _____
Cold hands L/R _____
Nails brittle Y/N _____ Cuticles broken Y/N _____
Trembling of hands Y/N _____ Fingers Y/N _____
Swollen hands/fingers Y/N _____

CHEST/ABDOMEN

Chest pain L/Mid/R _____
Blood pressure _____ high _____ low
Heart Murmur Y/N Fast beat Y/N Slow beat Y/N
Stomach Pain Y/N Rib Pain Y/N _____
Abdominal pain Y/N L/R _____
Cough Y/N Short of breath Y/N Frequent Belching Y/N
Heartburn Y/N Sour stomach Y/N
Pain/bloating after eating Y/N
Immediately following Y/N
Within: 1 2 3 hours of eating
Intolerance to: fatty foods/raw foods/acidic foods

LOWER GI

Pain/burning on urination Y/N _____
Urinary Incontinence Y/N _____
Blood/Sugar in urine Y/N _____
Kidney/Bladder disease Y/N _____
Trouble starting/stopping urination Y/N _____
Bowel movements Y/N _____ times a day
Strain at stool Y/N Hemorrhoids Y/N _____
Intestinal parasites Y/N Polyps/fissures Y/N _____
Rectal gas Y/N Diarrhea Y/N Constipation Y/N
Stool – Hard/Soft Usual color – Light/Brown/Black

LOW BACK

Pain near kidneys Y/N L/R _____
Low back pain Y/N L/Mid/R _____
Hip Pain Y/N L/R _____
Groin pain Y/N L/R _____
Buttocks pain Y/N L/R _____
Thigh pain/numbness/cramps L/R _____
Numbness/tingling in toes Y/N L/R _____

WOMEN ONLY

Menstrual History:
Age at onset _____
Usual duration of period _____ days
Cycle from start to start _____ days
Date of last period _____
Heavy flow _____ days
Cycle characteristics:
Medium flow _____ days
Light flow _____ days
Premenstrual tension:
depression _____
menstrual cramps _____
abdominal _____
breast soreness _____
pill use: _____ how long _____
tubal ligation _____
hormonal therapy Y/N How long _____
Pain with intercourse Y/N _____
Bleeding between periods Y/N _____
Recurrent yeast or vaginal infections Y/N _____
Menopause Y/N At what age _____
Pregnancies _____
Hot flashes Y/N _____
Abortions Y/N _____
Children born alive, how many _____
discharge _____
Breast:
cystic mastitis _____
cancer _____
bloating _____
pain _____
how long _____
low back pain _____

MEN ONLY

Prostate trouble Y/N _____
Pain/lumps in testicles Y/N _____
Discharge in underwear Y/N _____
Inability to achieve erection Y/N _____
Lack of ejaculation Y/N _____
Premature ejaculation Y/N _____
Vasectomy Y/N _____

LOWER EXTREMITIES

Knee Pain Y/N L/R Front/Back Inside/Outside
Torn cartilage in knee Y/N _____
Shin splints Y/N L/R _____
Calf cramps Y/N During activity Y/N At rest Y/N
Ankle swelling Y/N L/R Ankle sprain Y/N L/R
Torn ligaments Y/N L/R _____
Foot pain Y/N L/R _____
Cold feet Y/N L/R Burning feet Y/N L/R
Arch Pain Y/N L/R Heel Pain Y/N L/R
Toe Pain Y/N L/R Which toe/s _____

SKIN

Sensitive/Tender Y/N _____
Tendency to rashes Y/N _____
Tendency to infections Y/N _____
Psoriasis Y/N _____
Eczema Y/N _____
Acne Y/N _____
Stretch Marks Y/N _____
Bruise easily Y/N _____

GENERAL

Appetite: Poor/ Good /Always Hungry
Energy level: High / Low
Night sweats Y/N_____
Like sweets Y/N _____
Fly off the handle Y/N _____
Spells of exhaustion/fatigue Y/N _____
Difficulty handling stress Y/N _____
Worry about health Y/N _____
Are you from a nervous family Y/N _____
Are you upset by criticism Y/N _____
Do you exercise Y/N If so briefly describe type and frequency:
_____
_____
_____
Further comments:_____
_____

Do you use: Coffee / Tea / Cola _____cups/day/week
Alcohol – Hard Y/N _____cups/day/week
Alcohol – Soft Y/N _____cups/day/week
Cigarettes Y/N _____packs/day/week

Relationship with spouse/significant other:
Poor Fair Good Excellent
Stress at present job: Mild / Moderate / Severe
Other sources of stress: Relatives / Friends / Financial
Difficulty falling asleep or staying asleep Y/N
Awakened by frightening dreams Y/N
Difficult to make up mind Y/N
Inability to concentrate Y/N
Do you usually feel unhappy/depressed Y/N
Do you often cry Y/N

PRESCRIPTION MEDICATIONS:

Please include all prescription/over the counter drugs:
Name Dosage Frequency
_____
_____
_____
_____
_____
_____
_____

15. Medical History: Print the names of your relatives, living or dead, in the list at the left. Place an (X) in the appropriate column for any illnesses that you or your relatives listed at the left have had and list any others below, as well as more specific information where applicable:

Adopted Yes/No Birth: Normal Breech Forceps Caesarean **Childhood:** Measles Mumps	Allergies	Anemia	Arthritis/Gout	Asthma/Hay fever	Bleeding/Bruising Problems	Cancer or Tumors	Convulsions/Epilepsy	Diabetes	Drinking or Drug Problems	Eczema	Emphysema	Heart Trouble/Rheumatic Fever	Hepatitis/Mononucleosis	High Blood Pressure	Frequent Infections	Kidney or Bladder Problems	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Pneumonia/Bronchitis	Polio	Prostate Problems	Scoliosis/Back Problems	Stomach or Intestinal Disease	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Syphilis)	Weight Problem
Your Illnesses																															
Father																															
Mother																															
Brothers or Sisters																															
Children:																															
Grandparents																															

Note: This office will prepare any necessary report and forms to assist in making collections from the insurance company to the patient, or any amount authorized to be paid directly to this office will be credited to the patient's account. It should be understood that all non-contracted services furnished are charged directly to the patient, who is personally responsible for payment including the small charge for completing the forms. Payment is expected at the time of service, unless other arrangements are arranged prior to examination.

I have filled out the above form to the best of my ability and agree to the office policy.

Person Responsible for account: _____
Patient's Signature _____ Date _____

VERIFICATION OF INSURANCE COVERAGE

(Be sure to ask for <u>chiropractic</u> benefits.)

Name of Insured:_____

Name of Patient:_____ID or Contract # _____

Insurance Company:_____ Telephone #_____

Name of Insurance Rep spoken with:_____

Effective Date of Policy:_____

Deductible:_____ Met:____ Not Met:____

Referral needed? yes _____no _____ [Some policies require a referral for any benefits. Others require a referral for highest level of benefits, but the member may self-refer for a lower level of benefits.]

Benefits with Referral
Insurance Covers:_____%
Copay:_____
X-rays covered:_____%

Benefits Without Referral
Insurance Cover:_____%
Copay:_____
X-rays covered:_____%

Max visits allowed:_____ Max $$ amount:_____

Accident rider:_____ **PCP**:_____

Pre-existing conditions are _____waived _____not waived

Does policy include carry over clause for deductible? Yes_____ No_____

Does policy have out of network coverage? Yes_____ No _____

The Doctor's treatment plan will be based upon what he determines is in the best interest for your health and benefit. <u>Please note</u>: We have no influence over your insurance company's reimbursement policies or rationales for denials. We will report clinical information to your Primary Care Physician and insurance company to ensure maximum benefit reimbursement. However, please be aware that you will be responsible for the cost if your insurance company limits the number of adjustments, exams or services, (ie: modalities, exercises, etc.).

_____ _____
Patient Signature Date

_____ _____
Witness Date