CONNECTICUT FAMILY CHIROPRACTIC CENTER

Back & neck pain relief you can count on, results you can believe in

Account #_____

Dear patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Name_____ ☐ Male ☐ Female Social Security #_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Age_____ Birthday_____ Marital Status M S W D
Cell Phone_____ # Children_____ Spouse's Name_____
Work Phone_____ Who may we thank for referring you?_____
Occupation_____ E-mail address_____
Name and address of employer_____

HEALTH INFORMATION

Have you had previous chiropractic care? ☐Yes ☐No
Main Complaint_____
_____
Other Complaints_____
How long have you had this condition?_____
Have you had similar conditions in the past year?_____
Does this condition affect your work? ☐ Yes ☐ No
Does this condition affect your family or social life? ☐ Yes ☐ No
What aggravates this condition?_____
Other doctors seen for this condition?_____
Are you taking any medication? ☐ Yes ☐No
If yes what are you taking?_____
Have you ever had any major illness or been hospitalized? If yes, give details._____
_____
Date of last physical examination:_____
Name of your primary care provider:_____ Phone Number_____
Is your condition due to a work related injury? ☐ Yes ☐ No Date of accident_____
Is your condition due to an automobile accident? ☐ Yes ☐ No Date of accident_____

DO YOU SUFFER FROM

Headaches	☐ Yes ☐No	Neck Pain	☐ Yes ☐No	Arm/Shoulder Pain	☐ Yes ☐No
Back Pain	☐ Yes ☐No	Hip or Leg Pain	☐ Yes ☐No	Chest Pain	☐ Yes ☐No
Abdominal Pain	☐ Yes ☐No	Sinus Trouble	☐ Yes ☐No	Heart Trouble	☐ Yes ☐No
Palpitations	☐ Yes ☐No	Circulatory Problems	☐ Yes ☐No	High/Low Blood Pressure	☐ Yes ☐No
Female Problems	☐ Yes ☐No	Prostate Disorder	☐ Yes ☐No	Kidney Problems	☐ Yes ☐No
Bladder Problems	☐ Yes ☐No	Lung Problems	☐ Yes ☐No	Digestive Disorder	☐ Yes ☐No
Constipation	☐ Yes ☐No	Loose Stool	☐ Yes ☐No	Diabetes	☐ Yes ☐No
Swollen Joints	☐ Yes ☐No	Insomnia	☐ Yes ☐No	Dizziness	☐ Yes ☐No
Numbness	☐ Yes ☐No	Depression	☐ Yes ☐No	General Fatigue	☐ Yes ☐No
Morning Fatigue	☐ Yes ☐No	Anemia	☐ Yes ☐No	Poor Memory	☐ Yes ☐No
Hot Flashes	☐ Yes ☐No	Osteoporosis	☐ Yes ☐ No	Rheumatoid Arthritis	☐Yes ☐ No

INSURANCE INFORMATION

Do you have health insurance? ☐Yes ☐ No If yes insurance company name:_____
If yes please give insurance card (s) to front desk for copies to be made.