WELCOME TO BILLINGS FAMILY CHIROPRACTIC

Dear Patient: Please complete this questionnaire. Your answers will help us evaluate your condition. Thank you!

Please print.

Name _____ Today's Date _____

Address _____ Marital Status _____

City, State, Zip _____ Employer _____

Home Phone (____) _____ Work Phone (____) _____

Birth Date _____ Age ____ ❑ Male ❑ Female Spouse's Name _____

Social Security # _____ Spouse's Employer _____

# of Children ____ Occupation _____ Work Phone (____) _____

Who is responsible for this account? _____ Spouse's Social Security # _____

How were you referred to our office? ❑ Friend ❑ Relative (Name please:) _____

❑ Location / Sign ❑ Phone Book ❑ Radio ❑ Health Care Class ❑ Doctor (Name please:) _____

Have you ever had chiropractic care before? ❑ Yes ❑ No. If yes, when? _____

What is your understanding of chiropractic? _____

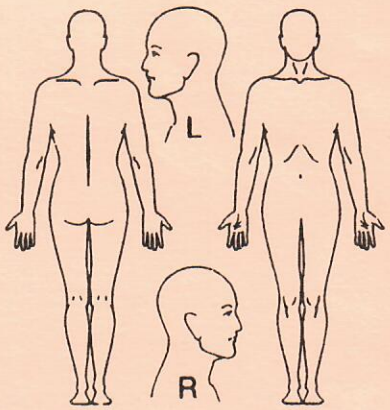
What is / are the major reason(s) you are here today? _____

If you are in pain, please grade the pain on a scale of 1 to 10: _____ (1 being slight pain, 10 being severe pain)

How long have you had this condition? _____ *How often?* _____

Is this condition getting progressively worse? ❑ Yes ❑ No *Would you say it* ❑ Comes and goes? *or* ❑ Is constant?

Shade in the areas on the diagram at right where you feel discomfort or symptoms (Examples: Pain, Numbness, etc.)



How many times have you had a problem similar to or the same as this in the past? (Count episodes that lasted at least one day, but eventually went away completely.)

❑ None previously ❑ 1-5 Episodes ❑ 6-10 Episodes

❑ More than 10 Episodes ❑ Single Episode of Continuous Pain

When was the very first time you ever felt something similar or the same as your current problem?

❑ Less than 6 months ago ❑ 6 Months - 1 year ago ❑ 1-5 Years ago

❑ 5-10 Years ago ❑ 10-20 Years ago ❑ More than 20 years ago

Have you seen a Medical Doctor or Chiropractor for this problem? ❑ Yes ❑ No If yes, please name: _____

When were you seen? _____ *Were x-rays taken?* ❑ Yes ❑ No

What type of treatment was done? _____

How much did it help, on a scale of 1-10? (1 being no improvement, 10 being full improvement.) _____

Is this related to a recent work / auto accident? ❑ Yes ❑ No *If yes, was it reported to your employer / auto insurer?* ❑ Yes ❑ No

Please list surgical operations and years: _____

_____

Drugs you now take: ❑ Nerve Pills ❑ Pain Killers ❑ Muscle Relaxers ❑ Tranquilizers ❑ Birth Control Pills

❑ Other (prescription or over-the-counter): _____

Do you take vitamins? ❑ Yes ❑ No If yes, please describe: _____

Your height: _____ Weight: _____

Date of last spinal exam: _____ *Date of last spinal x-ray:* _____

Please list all conditions for which you have been treated in the last 10 years: _____

_____

_____

_____

_____

Which of the following most closely fits your own philosophy of health?

❑ "An ounce of prevention is worth a pound of cure." ❑ "If it's not broken, don't fix it."

Please check the appropriate boxes:

Alcohol	❑ Heavy	❑ Moderate	❑ Light	❑ None
Coffee / Caffeine	❑ Heavy	❑ Moderate	❑ Light	❑ None
Tobacco	❑ Heavy	❑ Moderate	❑ Light	❑ None
Drugs	❑ Heavy	❑ Moderate	❑ Light	❑ None
Exercise	❑ Heavy	❑ Moderate	❑ Light	❑ None
Sleep	❑ Heavy	❑ Moderate	❑ Light	❑ None
Stress Level	❑ Heavy	❑ Moderate	❑ Light	❑ None

Do you have any type of health insurance? ❑ Yes ❑ No If yes, company name: _____

Method of payment you will be using for today's charges: ❑ Check ❑ Cash ❑ Mastercard ❑ Visa

NOTICE: If your care warrants x-ray analysis, the following office policy prevails:
1) All first visit charges are payable when services are rendered, unless prior arrangements have been made.
2) The fee paid for x-rays is for analysis only. The film itself is the property of this office. Once films are used for analysis purposes, they cannot be released unless requested by another healthcare practitioner.

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home):

Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ Zip _____

Patient's Signature _____