# Haddock Chiropractic

## New Patient Questionnaire

Name _____ Date _____ SS# _____

Mail Address _____ City _____ State ____ Zip _____

Birthdate _____ Home Phone _____ Cell _____

Work Phone _____ Email _____

◯ Male ◯ Female ◯ Single ◯ Married ◯ Employed ◯ Unemployed ◯ Retired ◯ Student

Occupation _____ Employer/School _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____ Relation _____

Name of Primary Physician _____ City _____ State ____

May we contact your physician? Yes ◯ No ◯ Do you have insurance? Yes ◯ No ◯

(Patient must provide copy of driver's license or photo ID) (If insured, provide copy of insurance card)

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Nature of Complaint(s): Automobile Accident ◯ Work Injury ◯ Sports Injury ◯ Other ◯

Current Complaint(s): _____

Date of Injury/When did it start? _____ How bad? _____ How Often? _____

Getting better/worse? _____ What activity bothers it the most? _____

When is it at its best? _____ When is it at its worst? _____

Rate your pain on the scale (1 = little to no pain; 10 = worst possible pain): ~~1 2 3 4 5 6 7 8 9 10~~

**Health History:**

List previous surgeries & dates:

_____

_____

_____

_____

_____

List all medications you are currently taking:

(including supplements & herbs)

_____

_____

_____

_____

_____

_____

*For women only*:

How many children do you have? _____

Are you currently pregnant?

Yes ◯ No ◯

Currently taking birth control pills?

Yes ◯ No ◯

Date of last menstrual cycle: _____

How did you hear about HADDOCK CHIROPRACTIC? _____

## Have you or a family member ever suffered from the following:

(immediate family only = list mother/father/sibling)

Check box if applicable.

| You | | Family | Which family member? | You | | Family | Which family member? |
|---|---|---|---|---|---|---|---|
| ☐ | **Allergies** | ☐ | | ☐ | **High Blood Pressure** | ☐ | |
| ☐ | **Anemia** | ☐ | | ☐ | **High Cholesterol** | ☐ | |
| ☐ | **Appendicitis** | ☐ | | ☐ | **Hot Flashes** | ☐ | |
| ☐ | **Athritis** | ☐ | | ☐ | **Kidney Infection** | ☐ | |
| ☐ | **Asthma** | ☐ | | ☐ | **Kidney Stones** | ☐ | |
| ☐ | **Back Pain** | ☐ | | ☐ | **Loss of Balance** | ☐ | |
| ☐ | **Breast Lump** | ☐ | | ☐ | **Loss of Smell** | ☐ | |
| ☐ | **Bronchitis** | ☐ | | ☐ | **Loss of Taste** | ☐ | |
| ☐ | **Bruise easily** | ☐ | | ☐ | **Migraines** | ☐ | |
| ☐ | **Cancer** | ☐ | | ☐ | **MS** | ☐ | |
| ☐ | **Chest Pain/Condition** | ☐ | | ☐ | **Neck Pain or Stiffness** | ☐ | |
| ☐ | **Cold Extremities** | ☐ | | ☐ | **Osteoporosis** | ☐ | |
| ☐ | **Constipation** | ☐ | | ☐ | **Pacemaker** | ☐ | |
| ☐ | **Depression** | ☐ | | ☐ | **Polio** | ☐ | |
| ☐ | **Diabetes** | ☐ | | ☐ | **Prostate Trouble** | ☐ | |
| ☐ | **Digestion Problems** | ☐ | | ☐ | **Rheumatoid (RA)** | ☐ | |
| ☐ | **Dizziness** | ☐ | | ☐ | **Sciatica** | ☐ | |
| ☐ | **Ear ringing** | ☐ | | ☐ | **Shortness of Breath** | ☐ | |
| ☐ | **Excessive Menstruation** | ☐ | | ☐ | **Sinus Infection** | ☐ | |
| ☐ | **Fatigue** | ☐ | | ☐ | **Stroke** | ☐ | |
| ☐ | **Fibromyalgia** | ☐ | | ☐ | **Thyroid Condition** | ☐ | |
| ☐ | **Headaches** | ☐ | | ☐ | **Tuberculosis** | ☐ | |
| ☐ | **Hemorrhoids** | ☐ | | ☐ | **Ulcers** | ☐ | |
| ☐ | **Herniated Disc** | ☐ | | ☐ | **Venereal Disease** | ☐ | |

| **Personal Habits:** | None | Light | Moderate | Heavy |
|---|---|---|---|---|
| Alcohol | ◯ | ◯ | ◯ | ◯ |
| Coffee | ◯ | ◯ | ◯ | ◯ |
| Tobacco | ◯ | ◯ | ◯ | ◯ |
| Drugs | ◯ | ◯ | ◯ | ◯ |
| Exercise | ◯ | ◯ | ◯ | ◯ |
| Sleep | ◯ | ◯ | ◯ | ◯ |
| Appetite | ◯ | ◯ | ◯ | ◯ |
| Water | ◯ | ◯ | ◯ | ◯ |
| Soft Drinks | ◯ | ◯ | ◯ | ◯ |
| Salty Foods | ◯ | ◯ | ◯ | ◯ |
| Sugary Foods | ◯ | ◯ | ◯ | ◯ |
| Artificial Sweeteners | ◯ | ◯ | ◯ | ◯ |

* All of the intake questions have been answered accurately. I understand that giving incorrect information can be dangerous. I authorize HADDOCK CHIROPRACTIC to release any information pertaining to my treatment to third party payers or other health care providers if HADDOCK CHIROPRACTIC deems it necessary. I authorize and request my insurance company to pay directly to HADDOCK CHIROPRACTIC any payable benefits. I further understand that payment from my insurance may be less than the actual cost of services and in that case, I will be responsible for any outstanding amount owed this office.

**Patient Signature:** _____ **Date:** _____