

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

List any surgeries or hospitalizations you have had complete with the month and year for each:

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

Do you exercise? Yes No Hours per week _____ What activity(s)? _____

Are you dieting? Yes No Since: _____ Do you smoke? Yes No _____ packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? Yes No _____ drinks per day.

Do you wear? Heal lifts Arch supports Prescription Orthotics

For women: Are you pregnant or nursing? Yes No If pregnant, How many weeks? _____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

Are you here because of an accident? _____ What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? _____

Have you experienced these symptoms in the past? _____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ___ No

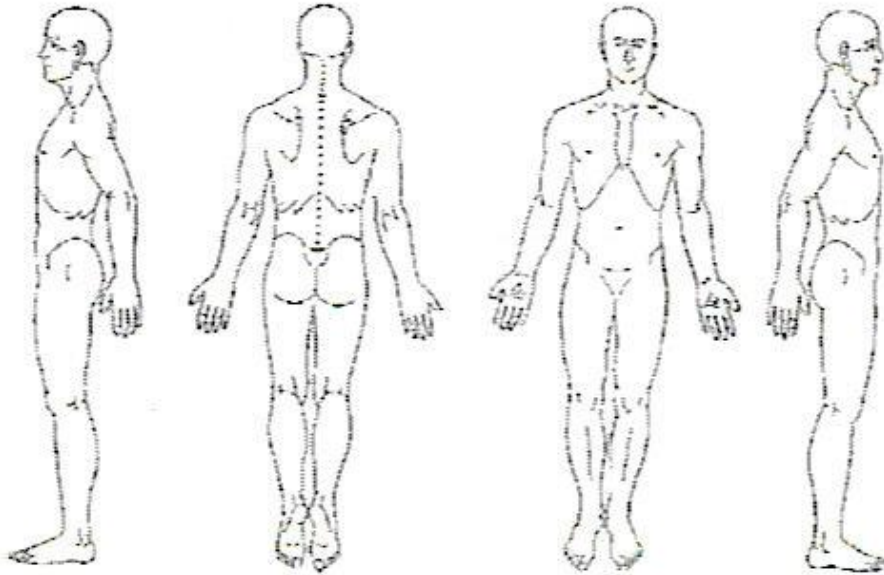
Have you seen a chiropractor before? ___Yes ___ No Who referred you to us? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left

Back

Front

Right

On a scale of one to ten how intense are your symptoms? Not intense ①②③④⑤⑥⑦⑧⑨⑩ Unbearable

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Elbow/upper arm pain	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder
<input type="radio"/>	<input type="radio"/>	Abnormal Weight gain/loss	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control
<input type="radio"/>	<input type="radio"/>	Allergies Headache	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Low back pain
<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>	Mid back pain
<input type="radio"/>	<input type="radio"/>	Ankle/foot pain	<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Neck pain
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Hand pain	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Shoulder pain
<input type="radio"/>	<input type="radio"/>	Birth Control Pills	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Smoking/tobacco Use
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Hip/upper leg pain	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Systematic Lupus
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Thoracic Outlet Syndrome
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Jaw pain	<input type="radio"/>	<input type="radio"/>	Tumor
<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Joint swelling/stiffness	<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Upper back pain
<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Knee/lower leg pain	<input type="radio"/>	<input type="radio"/>	Wrist pain

Additional comments you would like the doctor to know: _____

Patient's signature: _____ **Doctor's signature:** _____

Bennett Chiropractic PLLC

**Acknowledgement of Receipt of
Notice of Privacy Practices**

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____ **Date of Birth:** _____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Bennett Chiropractic PLLC.

I understand that the Notice describes the uses and disclosures of my protected health information by Bennett Chiropractic PLLC and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
 - Due to an emergency situation it was not possible to obtain an acknowledgement
 - Communications barriers prohibited obtaining the acknowledgement
 - Other (please specify): _____
- _____

Employee Name

Today's Date

Authorization and Assignment of Benefits

I hereby assign my insurance rights and benefits, now and hereafter, for the professional services of Dr. Ian A Bennett. I authorize payments to be made directly from Medicare, Private Insurance, Legal Settlements, or other Third Parties to Dr. Bennett for professional services rendered. I also hereby authorize Dr. Ian A. Bennett to release all information necessary to secure the payment for services rendered.

I understand that I am financially responsible for all charges not paid by my insurance company (or companies) including any deductibles and co-payments and that payment may be requested at the time services are rendered or at any time that the insurance claims are denied.

I understand that this office reserves the right to charge interest and collection fees for any delinquent balances once a request for payment has been issued.

Signed: _____ Date: _____

A NOTE TO OUR PATIENTS

Because of the high costs and the long periods of time required to file insurance claims, follow them up, and then bill our patients for the balance, Dr. Bennett can no longer wait for payment of the patient's portion of the bill until after the insurer has paid their portion. Therefore, we request that you make arrangements for your payment at the time of your visit.

PAYMENT PLAN / CREDIT AGREEMENT

I choose to make my payment by:

1. _____ Paying in full at the time of each visit by check, cash, or money order and accepting reimbursement from my insurer(s).
2. _____ Paying my co-pay or estimated portion of the bill at the time of each visit and authorizing Dr. Bennett's office to automatically bill my credit card for the amount I owe as specified on the Explanation of Benefits after my insurance company has processed the claim. I understand that if Dr. Bennett is a participating provider with my insurance plan, he will apply any contractual discounts before billing my credit card for the remaining balance.
3. _____ Paying my co-pay, deductible, or estimated portion of the bill at the time of each visit by check, cash, or money order. I guarantee that if there is any balance remaining that is my responsibility, I will pay it within 14 days of receiving an invoice from Dr. Bennett.

CHARGE THE FOLLOWING CREDIT CARD: Visa MasterCard AMEX Discover

Account # _____ Expiration Date: _____

Signed: _____

I certify that I have read the above and fully understand it.

Please Print Your Name: _____ Date _____