Ogi Chiropractic New Patient Questionnaire

Patient demographic information

Please Print

Date _____/_____/_____

Patient's Name_____ Birthdate____/_____/_____ Age _____

Mailing Address _____City_____ State_____ Zip_____

❑Male ❑Female

E-mail Address_____

Cell Phone _____ Home _____

Employer_____ Occupation _____

Spouse (Guardian if under 18) _____ Spouse's D.O.B ____/_____/_____ Phone_____

Emergency Contact_____ Relationship to you _____ Phone _____

Whom may we thank for referring you to us? _____

Name of local primary Physician_____ May we contact them if necessary? _____

SYMPTOMS

Main Complaint_____ How Bad? _____ How Often? Occasional Intermittent Frequent Constant

When did it start? _____ Progression: Getting Better / Getting Worse / Staying the same

What activity bothers it the most? _____

What activity relieves the discomfort? _____

When is it at its best? (morning / afternoon / night) When is it at its worst? (morning / afternoon / night)

Rate the pain - (0 is pain free - 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Nature of the Pain (circle any that apply) Dull Achy Tight Pulling Throbbing Sharp Stabbing Tingling Burning Numb Other_____

Other Chiropractic Experience? _____ Positive Experience? _____

Other type of physician/therapist for this complaint? Yes / No Positive Experience? Yes / No

Secondary Complaint_____

Rate Secondary pain - (0 is pain free - 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Health History - *Please circle all that apply*

Cancer Diabetes Heart Disease Prosthetic Implants Osteoporosis/Osteopenia

Type _____ Where? _____

Any Important Condition(s) Not Listed _____

Patient Height _____ Patient Weight _____

Do you have a pacemaker? YES□ NO□

Family History – Do you have any *family history* of ***Cancer***, ***Diabetes***, or ***Heart Disease***? (circle any that apply)

If so, who has (had) what? _____

Women - How many children? _____ Currently Pregnant? _____ Nursing? _____

Previous Surgeries & Dates: _____

Previous Accidents & Dates: _____

List ALL Medications you are currently taking _____

_____

What kind of exercise do you do? _____

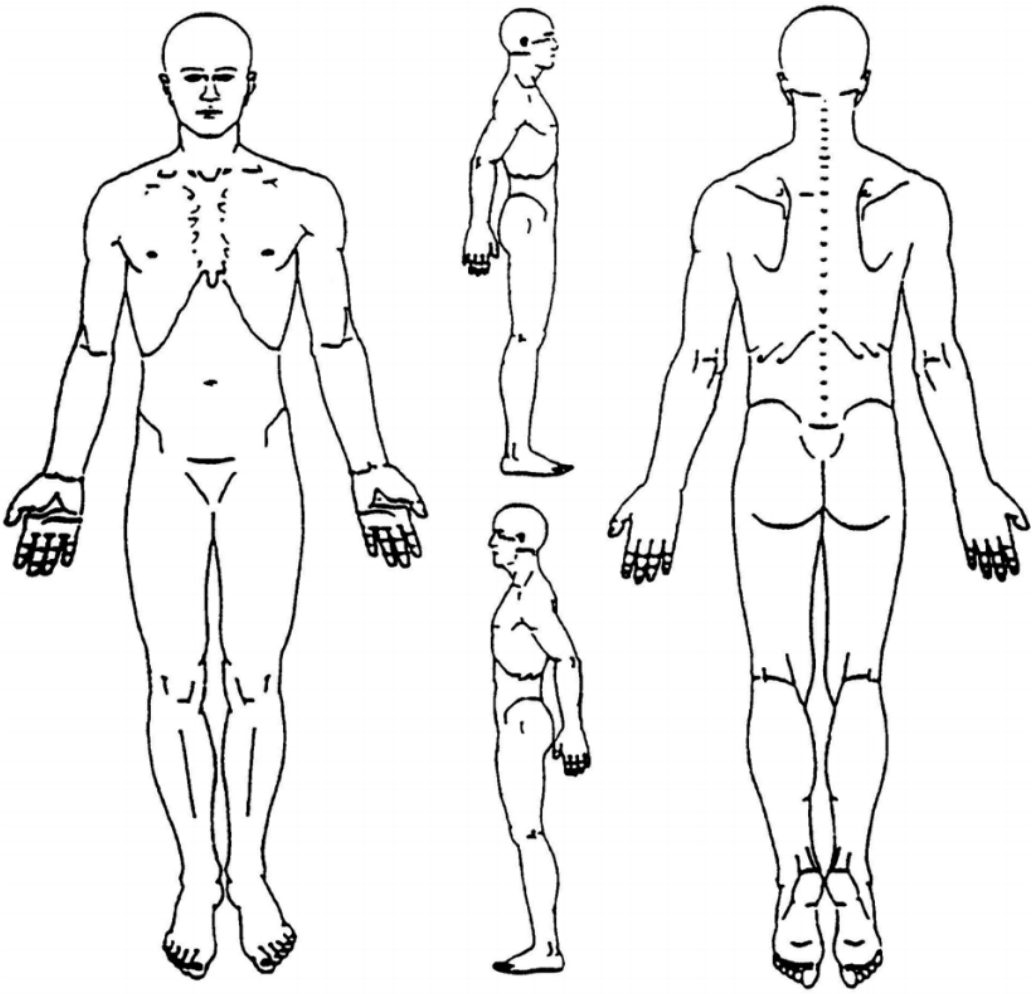
What supplements do you take? _____

How much do you smoke per day? _____ Alcoholic beverages per week? _____

Continued on opposite side

Patient's Name_____

Please show us where your discomfort is. **Use circles or X's**



Please elaborate on your condition (i.e. how and when did it start)

_____

_____

_____

_____

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

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to Ogi Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The doctor will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor. The Doctor of Chiropractic provides a specialized, non-duplicating health care service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care path to wellness. I understand that if I am accepted as a patient at Ogi Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature (or legal guardian) _____ Date____/_____/_____