

dr.



chiropractor

Today's Date: MM / DD / YYYY

Confidential Patient Questionnaire

Name: First M. Initial Last Male Female

Date of Birth: MM / DD / YYYY Social Security #: Martial Status: S M D W P

Address: Street Apt # City State Zip

Phone: Home () Cell () Work () ext:

Email:

Employer: Occupation:

Work Address:

Primary Health Care Physician: Phone: ()

How did you hear about Dr. Rocco Tetro D.C.?:

Health Insurance

Insurance Company: Phone: ()

Address:

Insured's Name: Relationship: self spouse child other

Insured's Employer:

Insured's I.D# or S.S#: Group: Insured's Date of Birth: / /

Please inform office if there is secondary insurance coverage. Please inform office if insurance coverage is through worker's comp. or personal injury insurance (auto)

Reason For Visit

Reason for today's visit:

.....

.....

Is this condition related to: Auto accident Slip/fall accident Work.

If so, please explain:

.....

Date this condition began: / / Has this condition recently worsened? If yes, when? / /

Is this condition getting worse? Yes No Is this condition: constant comes and goes

Is this condition interfering with: Work Sleep Daily routine

If so please explain:.....

.....

What makes your condition worse?..... Better?

How would you rate your health on a scale of 1 to 10? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

How would you rate your pain today? Mild 1 2 3 4 5 6 7 8 9 10 Extreme

How would you rate your average pain this past week? Mild 1 2 3 4 5 6 7 8 9 10 Extreme

Have you ever suffered from (please mark C for Currently, P for Past):

<input type="checkbox"/> headache	<input type="checkbox"/> numbness in arms	<input type="checkbox"/> allergies	<input type="checkbox"/> sensitivity to light
<input type="checkbox"/> neck pain	<input type="checkbox"/> tingling in arms	<input type="checkbox"/> asthma	<input type="checkbox"/> frequent painful urination
<input type="checkbox"/> neck stiffness	<input type="checkbox"/> numbness in legs	<input type="checkbox"/> ringing in ears	<input type="checkbox"/> abdominal pain
<input type="checkbox"/> shoulder pain	<input type="checkbox"/> tingling in legs	<input type="checkbox"/> loss of smell	<input type="checkbox"/> seizures/convulsions
<input type="checkbox"/> arm pain	<input type="checkbox"/> cold hands/feet	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> difficulty swallowing
<input type="checkbox"/> upper back pain	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> dizziness	<input type="checkbox"/> nausea/vomiting/diarrhea
<input type="checkbox"/> lower back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> trouble sleeping	<input type="checkbox"/> other intestinal problems
<input type="checkbox"/> hip pain	<input type="checkbox"/> general fatigue	<input type="checkbox"/> cold sweats	<input type="checkbox"/> unexplained weight loss/gain
<input type="checkbox"/> leg pain	<input type="checkbox"/> balance problems	<input type="checkbox"/> unexpected fever	<input type="checkbox"/> shortness of breath
		<input type="checkbox"/> chest pain	<input type="checkbox"/> palpitations

Have you been seen a medical physician for this condition? Yes No Was treatment effective? Yes No

Who treated you?..... When?.....

Have you ever received chiropractic care in the past? Yes No Was treatment effective? Yes No

Who treated you?..... When?.....

