

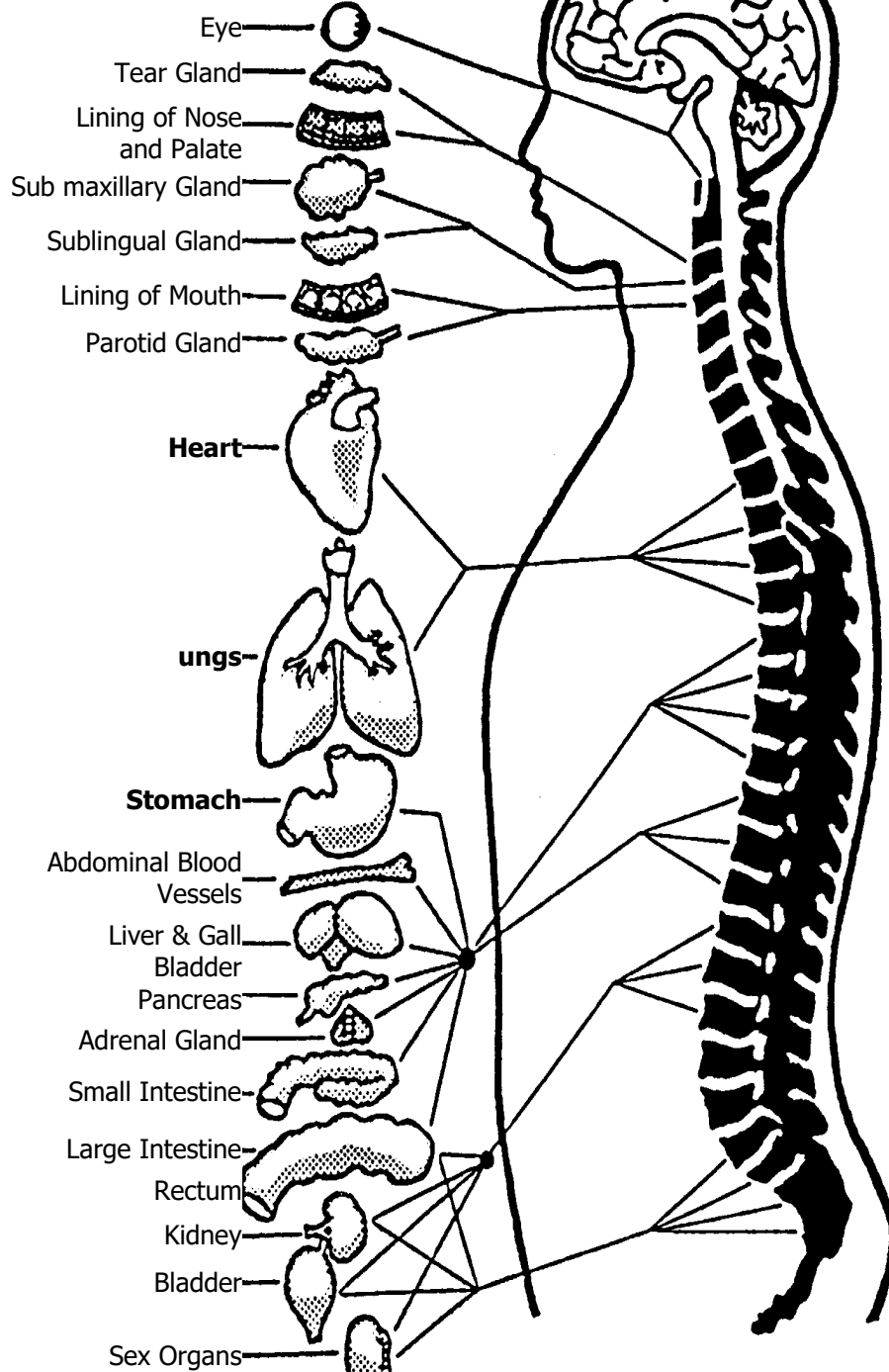
Bullitt Chiropractic, P.A.

Health Questionnaire

Patient's Name _____

Please circle area of pain or malfunction on diagram

Are you now or have you suffered from any of the following...
Check Appropriate Box.



- | Past | Present | No | |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Taste |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trouble Sleeping |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Smell |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Sore Throats |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent Coughs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor Digestion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed Wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sex Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tension |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |

Date _____

Symptoms related to the Autonomic Nervous System

Chiropractic deals with the relationship between your spine and nervous system. The Nervous System's function is to control and coordinate all these organs and structures. Pinched or irritated nerves may interfere with the function and thus cause a wide variety of symptoms.

Symptoms that can be related to Spinal Nerves

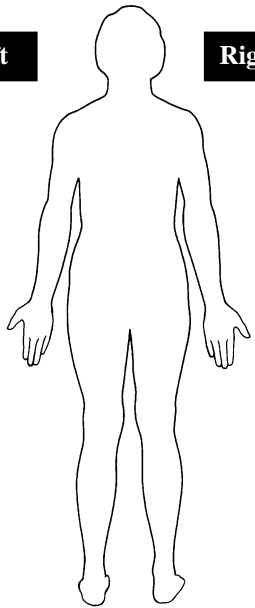
Please mark area of pain on diagram.

- | | | |
|--|--|-------------------------------------|
| Past
Present
No | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Scalp Disorders |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Head Pain or Headaches |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Shoulder Pain or Stiffness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Arm Pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Tennis Elbow |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Loss of Arm Power |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Loss of Grip |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Tingling, Numbness, or Pain in Hand |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Mid-Back Pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Mid-Back Tension |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Pain in Ribs |

- | | | |
|--|--|-------------------------------------|
| Past
Present
No | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Low Back Weakness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Low Back Stiffness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Hip Pain or Stiffness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Buttock Pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Leg Cramps |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Tingling, Numbness, or Pain in Leg |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Knee Trouble |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Foot Trouble |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Tingling, Numbness, or Pain in Foot |

Left

Right



Back

No Symptoms	Extreme Symptoms
<hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Please place an "X" on the line above to indicate your level of PAIN.	

Family History

	Father	Mother	Siblings	Grandparents	Children
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Members Still Alive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Hereditary Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many children do you have? _____
 What are their current ages? _____

Personal Habits

<u>Type</u>	<u>Amount</u>	<u>Per *</u>
Exercise	_____	_____
Dairy Products	_____	_____
Soda Pop	_____	_____
Coffee/Tea	_____	_____
Alcoholic Beverages	_____	_____
Tobacco (any type)	_____	_____
Drugs (any type)	_____	_____
Vitamins	_____	_____

* Please write Day, Week, or Month as applicable.

Occupation

What is your trade? _____

Does your job require you to:

- Sit Stand Bend Walk Lift

How much of each? _____

Dr. Notes: _____

BULLITT CHIROPRACTIC, P.A.
PATIENT CONDITION INFORMATION

Main complaint and symptoms: _____

Describe the pain: Sharp Dull Tightness Numbness Tingling Aching Burning Stabbing

Does the pain radiate into your arms or legs? yes no Which? _____

How frequent is the condition? Constant Intermittent Daily Night only

How long does it last? All Day A Few Hours A Few Minutes

When did you first notice this problem? _____

Has your condition improved gotten worse or stayed the same since its onset?

Was your condition caused or aggravated by and accident? yes no. **Date of Injury** _____

If your above answer is yes, please check the type of accident? Auto On Job Other

Describe the Accident _____

What makes your condition worse? Sitting Standing Lying Bending Lifting Twisting
 Other _____

Does anything make it feel better? _____

Have you had any previous treatment for this or similar conditions? yes no

When? _____ Treated how long? _____ Who treated you? _____

Results? _____

Have you been under previous chiropractic care? yes no Who? _____

List and describe the nature of any Surgery, Trauma, Injury, or Medications: _____

Women: Is there any possibility that your pregnant? yes no Date of Last Menstrual Period: _____

INFORMED CONSENT

Informed consent is more than just a signed document. The following categories will be or have been discussed.

- What's wrong? or your diagnosis.
- What tests will be ordered; the reason for them; and results expected to achieve.
- Whether or not Chiropractic can be helpful in this case.
- Alternative treatments and your options.
- A treatment plan outlined for your case with expected time frame for results.
- Cost of this Treatment.

These categories have been discussed with me in my report of findings; and I am authorizing the doctor to treat my conditions within the parameters outlined, to the best of his ability.

PATIENT'S SIGNATURE _____ **DATE:** _____

Patient's Printed Name _____

BULLITT CHIROPRACTIC, P.A.

PATIENT INFORMATION

NOTE: PLEASE COMPLETE THIS FORM WITH YOUR SIGNATURE AT THE BOTTOM OF THE PAGE

Patient's Name: _____ Nickname: _____

Address including City, State, Zip : _____

Email Address: _____ Cell Phone & Carrier: _____

Birth Date: _____ Sex: M F Marital Status: M S W D

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Name and Age of Children: _____

Name of your physician: _____ Would you like a report sent to him/her? yes no Phone # _____

Name and number of Nearest Relative not living with you _____ Phone # _____

Who or What Referred you to the office of BULLITT CHIROPRACTIC? _____

INSURANCE INFORMATION*

**Please complete this section in full if you are covered by insurance or are entitled to receive benefit payments.*

This information will assist us in helping you obtain the benefits in which you may be entitled.

Name of Insurance Company _____

Address _____

Name of Primary Insured: _____ Insured's Birth Date: _____

Insured's Employer: _____ Type: Group Private Workman's Comp Automobile

Policy# _____ Group# _____ Membership Phone # _____

PATIENT CERTIFICATION AND SIGNATURE

I, the patient, certify that the above information is true and correct. I hereby authorize the release of any information required to secure payment for services rendered. I also authorize and direct that any insurance or medical coverage benefit payments to which I may be entitled shall be paid directly to **Bullitt Chiropractic, P.A.**

I understand and agree that I am financially responsible for and will promptly pay any non-covered services including, but not limited to, deductible and copay.

I, the patient, understand and agree to allow this chiropractic office to use their Patient Health information for the purpose of treatment, payment, healthcare operations, and coordination of care.

PATIENT'S SIGNATURE _____ **DATE:** _____

We, at Bullitt Chiropractic, want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT'S SIGNATURE _____ **DATE:** _____