Total Health of Vero Beach New Patient Questionnaire

Patient Information

Please Print

Name_____ Date_____
Address_____City_____State_____Zip_____
Seasonal Address_____City_____State_____Zip_____

Male Female Married Single Widowed Divorced Separated
Birthdate_____Home Phone_____Cell Phone_____Work Phone_____

Email Address (required)_____
Employer_____Occupation_____# years_____
Spouse or Parent Name_____Birthdate_____Phone #_____
Emergency Contact_____Phone #_____Relation_____
Name of Local Primary Physician_____May we contact them?____

How did you hear about us?_____
Did you see our? Web Page?_____ Facebook?_____ Business Sign?_____ Word of mouth?_____

Symptoms

Main complaint_____When did it start_____
How did it start_____
_____
What activity bothers it most_____Getting Better/Worse?_____
When is the pain at its worst? (Circle) AM PM Mid Day Sleep Sitting Moving Resting Working
Rate the pain - (0 pain free – 10 unbearable pain) 0 1 2 3 4 5 6 7 8 9 10
Secondary Complaint_____

Other chiropractors? _____ Positive experience?_____Last Visit?_____
Other type of physician or therapist?_____Positive experience_____

Health History – Please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthiritis	Asthmas	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken Pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart Dx
Hepatitis	Hernia	Herniated Disc	Herpes	Hi Cholesterol	Kidney Dx	Liver Dx	Measles
Migraines	Miscarriage	Mono	M.S.	Mumps	Osteoporosis	Pacemaker	Parkinson's
Pneumonia	Polio	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Chronic Fatigue	Hi Blood Pressure		Fibromyalgia	Other_____			

Women – How many children?_____ Are you pregnant?_____Date of Last Menstrual Cycle_____
Nursing?_____ Taking birth control pills?_____

Previous surgeries and dates_____
_____
List all medication your are currently taking_____
What kind of exercise do you do?_____
What supplement do you take?_____
How much do you smoke per day?_____ Drink per week?_____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous and can hinder treatment. 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 money amount owed to this office.

Patient signature_____ **Date**_____