

Welcome to Chanute Chiropractic Center

The following questionnaire will help us help you. All information is strictly CONFIDENTIAL. Please fill out this form as thoroughly as possible and please do not hesitate to ask for help.

Patient Information

First Name _____ M.I. _____ Last Name _____ I like to be called _____

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of birth _____ Age _____ Male () Female ()

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Spouse's name _____

Home Phone# _____ Alternate Phone# _____ E-mail _____

How did you hear about our office? If patient please give name _____

Employer Information/Parent Information/Insured's Information

Employer Name _____ Employer Phone# _____

Employer Address _____ City _____ State _____ Zip _____

Occupation _____ Insured's B-Day and SSN _____

General Information

Please Circle One
Rate the severity of your pain 1 2 3 4 5 6 7 8 9 10

Reason for today's visit _____ Date symptoms appeared or accident occurred _____

Describe how you injured yourself _____

If this is a recurrence, when did it originally occur? _____

Have you had any major surgeries or serious illnesses? If yes, describe and give dates _____

What medications are you taking? _____

Are you taking anything for this condition? _____

Have you had any tests for this condition? (X-Ray's or MRI) _____

Have you ever received chiropractic care before? If yes, how long ago? _____

Family Medical Doctor _____ Have you seen them for this condition? _____

Please mark the areas of complaint on the pictures to the right and use the space below to describe your symptoms.



1. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____
Burning _____ Stabbing _____ Other _____
2. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night only _____

3. How long does it last? All Day _____ Few Hours _____ Minutes _____
4. Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
Yes _____ No _____ If yes, describe _____
6. Is there anything you can do to relieve the problem? Yes _____ No _____
If yes, describe _____
If no, what have you tried that has not helped _____
7. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____
Lifting _____ Twisting _____ Other _____
8. Have you had any broken bones? Yes _____ No _____ If Yes, please list and give dates _____
9. List any major accidents you have had other than those that might be mentioned above: _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes _____ No _____ Uncertain _____
- Additional remarks _____

Authorization & Payment Responsibility

1) I authorize the use of this signature on all insurance submissions. 2) I authorize and request my insurance company to pay directly to Chanute Chiropractic Center benefits payable to me. 3) I understand that my insurance may pay less than the actual bill for services or supplies, or may not cover my services or supplies. 4) I agree to be responsible for payment of all services and/or supplies rendered to me or my dependants. 5) Should your account have to go to a collection agency or an attorney for reasons of non-payment, I agree to pay collection and/or attorney fees.

Responsible Party Signature _____ Date _____

- I have read and understand the Informed Consent to Care. _____
- I have read and understand the Privacy/HIPAA Policy. _____