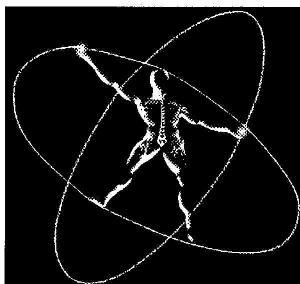
Welcome



EDWARDS CHIROPRACTIC
& ACUPUNCTURE CENTER

New Patient Questionnaire

Name_____________________________________ Date of Birth ______________ Today's Date_______________

Mailing Address____ Home Phone_______________

City _____________________________ State ________ Zip __________________ Work Phone_______________

E-Mail Address____ Cell Phone _______________

Occupation ___________________________________ Employer ____

Spouse Name _________________________________ Employer ____

I was referred by:______________________________

Primary Insured Social Security Number___________________________

Insurance Carrier ____

Policy or Group Number ________________________ Insurance Co. Phone Number_________________________

PLEASE READ CAREFULLY

It is the policy of this office that payment is made at the time of treatment, unless other arrangements have been made. If desired, please ask for an estimate of fees before beginning treatment. You should familiarize yourself with your insurance plan's coverage of chiropractic and acupuncture treatments. We will do our best to help you with your insurance filing. **Ultimately you are responsible for the payment of your treatment.**

This office does accept billing on PIP Auto Claims and authorized Worker's Compensation cases. We participate in Cofinity and Aetna. ** A copy of our "Notice of Privacy Practices" is provided for your careful review. I have read your "Privacy Practices" policy:_______________**

IF YOU HAVE ANY QUESTIONS, PLEASE ASK

____ ___________________________

Patient's Signature Date

Confidential Case History

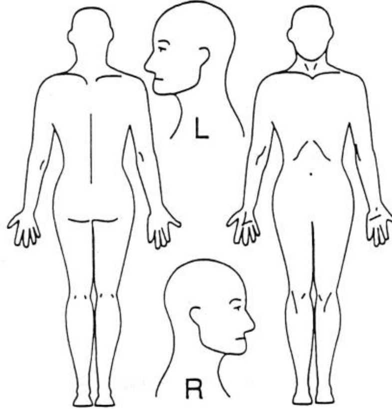
1. Please describe the health problem for which you came to our office ___________________________________

   ____

2. How long have you had this condition? ____

   Have you had this or similar conditions in the past? ____

3. Shade in the areas on the diagram below where you feel discomfort or symptoms.



4. Did your condition begin gradually or suddenly? *(circle one)*

5. Since your condition began has it worsened, stayed the same, comes and goes? *(circle one)*

6. What aggravates your current condition? ____

   ____

7. Is this condition interfering with your work, sleep or daily routine? *(circle one)*

8. Is your condition the result of an auto accident, work injury or other personal injury? *(circle one, if applicable)*

9. Have you done anything to try to help or relieve your complaint such as rest, heat, cold, aspirin, medications, sitting, lying down or other?____

10. Do you exercise? *(circle one)* Never Moderately Daily

11. Have you ever had previous chiropractic/acupuncture care? If yes, date of care ___________________________

12. Please list any operations/hospitalizations, years and circumstances. ___________________________________

    ____

13. Do you smoke or use tobacco products? ____________________If yes, how often? ________________________

14. Do you drink alcoholic beverages? ________________________If yes, how often? ________________________

15. Do you drink caffeinated beverages? _______________________If yes, how often? _______________________

16. Please list all medication or supplements that you are presently taking ________________________________

Medical History

A complete history and understanding of your health will facilitate care.

Are you now, or have you ever suffered from the following? **(Check only those that apply.)**

GENERAL
_____Fatigue
_____Headache
_____Fever
_____Chills
_____Night Sweats
_____Dizziness
_____Fainting
_____Convulsions
_____Loss of Sleep
_____Loss of Weight
_____Nervousness
_____Depression
_____Numbness
_____Nerve Pain
_____Irritability
Allergies (list)
____
____
____

PULMONARY
_____Chronic Cough
_____Difficult Breathing
_____Phlegm (color)
____
_____Chest Pain
_____Wheezing

GENITO-URINARY
_____Frequent Urination
_____Inability to Control Kidneys
_____Kidney Infection or Stones
_____Painful Urination
_____Pus in Urine
_____Prostate Problems
_____Pain in the Loins
_____Kidney Disease
_____Bed Wetting

MUSCULO-SKELETAL
_____Weakness
_____Twitching
_____Arthritis
_____Bursitis
_____Low Back Pain
_____Neck Pain or Stiffness
_____Pain between shoulders
Pain or Numbness in:
_____Shoulders
_____Arms
_____Elbows
_____Hands
_____Hips
_____Legs
_____Knees
_____Feet
_____Swollen Joints
_____Foot Problems
_____Spinal Curvature
_____TMJ

GASTRO-INTESTINAL
_____Belching or Gas
_____Colon Problems
_____Constipation
_____Diarrhea
_____Difficult Digestion
_____Poor Appetite
_____Excessive Hunger
_____Gall Bladder Problems
_____Hemorrhoids
_____Liver Problems
_____Nausea
_____Pain Over Stomach
_____Vomiting
_____Vomiting of Blood

MEN ONLY
_____Prostate Problems

EYES/EARS/NOSE/THROAT
_____Frequent Colds
_____Poor Vision
_____Pain in Eyes
_____Earache
_____Ear Noises
_____Ear Discharges
_____Enlarged Glands
_____Sore Throat
_____Tonsilitis
_____Hoarseness
_____Nasal Obstruction
_____Nose Bleeds
_____Sinus Infections

CARDIO-VASCULAR
_____Rapid Heart
_____Slow Heart
_____High Blood Pressure
_____Low Blood Pressure
_____Hardening of Arteries
_____Pain Over Heart
_____Swelling of Ankles
_____Poor Circulation
_____Stroke
_____Heart Attack

SKIN
_____Skin Eruptions
_____Itching
_____Bruising Easily
_____Dryness
_____Boils
_____Sensitive Skin
_____Hives
_____Eczema
_____Varicose Veins

WOMEN ONLY
_____Painful Periods
_____Congested Breasts
_____Cramps
_____Excessive Menstrual Flow
_____Miscarriage
_____Irregular Cycle
_____Vaginal Discharge
_____Are you pregnant?
Date of Last Menstrual Period
____

Do you have any other condition, disease or ailment not listed above?____________________________________

Have you been in an automobile accident? (circle one) PastYear Past 5 Years Over 5 Years Never

Fractures?____ Dislocations?____

Have you ever been on crutches? Yes No Why?____

Have you ever had spinal injections? Yes No Were you ever knocked unconscious? Yes No

Have you ever had a MRI or CT Scan? Yes No Have you ever had x-rays taken? Yes No

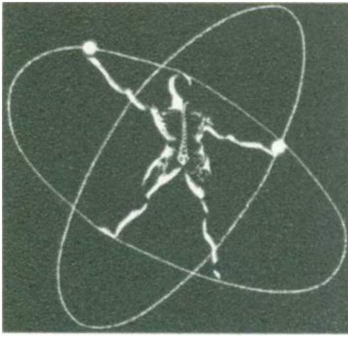
For what ailments were these pictures taken? ____

FAMILY HISTORY

	Diabetes	**Heart**	**Kidney**	**Cancer**	**Back**	**Lung**	**Liver**	**Thyroid**
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐

I have read the above information. To the best of my knowledge, the above questions have been answered accurately.

Patient's Signature____ Date______________________________



Edwards Chiropractic & Acupuncture Center, LLC
PO Box 1967 - Edwards, CO 81632-1967

Eric Eckdahl, D.C.
Christine Labadie, D.C.

PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (4 pages) for Edwards Chiropractic and Acupuncture Center, LLC, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

____________________________________ ________________
Patient Signature Date

____
Print the Patient Name

03/2016 clp