

ADVANCED CHIROPRACTIC RELIEF DR. GREGORY E. JOHNSON, D.C.
PATIENT QUESTIONNAIRE

PATIENT INFORMATION:

PATIENT Id: _____

Please Print

Name _____ Date ___/___/___ SS# _____

Address _____ City _____ State _____ Zip _____

Seasonable Address _____ City _____ State _____ Zip _____

Male ___ Female ___ Married ___ Single ___ Widowed ___ Divorced ___ Separated ___

Birthdate _____ Home Phone _____ Cell _____

Work phone _____ E-mail Address _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Birthdate _____ Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Whom may we thank for referring you to us? _____

Did you see our Flyer? _____ Web-Site? _____ Yellow page ad _____ Other _____

Name of local primary Physician _____ May we contact them? _____

INSURANCE INFORMATION-IF INSURED, PLEASE PROVIDE COPY OF INSURANCE CARE

SYMPTOMS

Main complaint: _____ How bad? _____ How often? _____

When did it start? _____ Getting worse? _____ Getting Better? _____

What activity bothers it the most? _____

When is it at its best? _____

When is it at its worst? _____

Rate the pain: (0 is no pain-10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors? _____ Positive Experience? _____

Other type of Physician or Therapist? _____ Positive Experience? _____

Secondary complaint: _____

HEALTH HISTORY-PLEASE CIRCLE ALL THAT APPLY

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis
Asthma	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	High Cholesterol	Kidney dx
Liver dx	Measles	Migraines	Miscarriage	Mono	M. S.
Mumps	Osteoporosis	Parkinson's	Polio	Pacemaker	Pneumonia
Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.
Whooping Cough	Chronic Fatigue	High Blood pressure	Fibromyalgia	Other _____	

Women-How many children? ___ Pregnant? ___ Date of last Menstrual cycle? _____ Nursing? ___ Taking birth control? ___

Previous Surgeries and Dates? _____

List ALL Medications you are currently taking _____

What kind of exercise do you do? _____ What Supplements 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. 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 (ies) 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 amount owed this office.

PATIENT SIGNATURE _____ DATE ___/___/___