

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Patient: _____ **Date:** _____
No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulder:
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?
 YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus

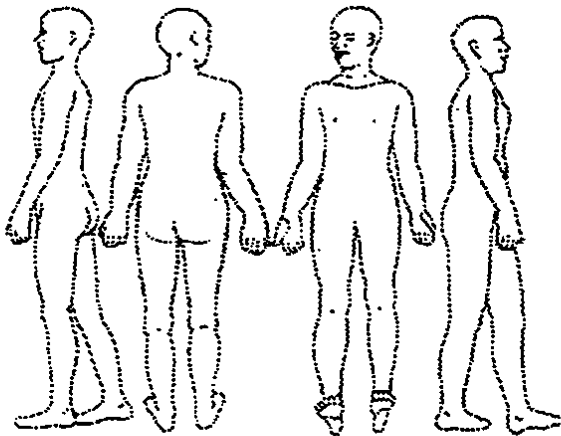
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

* * * * * DO NOT WRITE BELOW THIS LINE * * * * *

Patient Accepted? YES NO Doctor's Signature _____

PATIENT PERSONAL / CONFIDENTIAL DATA

No. _____ Date: _____

Patient: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Address: _____ City: _____ State: _____

Name of Spouse: _____ SSN: _____ No. of Children: _____

Spouse's Employer: _____ Address: _____

How did you learn of this clinic? _____ Email Address: _____

Nearest relative not living with you? _____ Phone: _____

Who is responsible for payment? Self Spouse Other _____

PATIENT'S INSURANCE Card D. Lic

Name of Company: _____

Address: _____

ID & Group No: _____

Phone No: _____

SPOUSE'S INSURANCE

Name of Company: _____

Address: _____

ID & Group No: _____

Phone No: _____

Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ AM PM Location: _____

How did accident occur? Auto On the job Other: _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

Other Doctor seen for this condition: _____

Have you been treated by a Doctor for any health conditions in the last year? Yes No

If yes, please describe: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Hinz Family Chiropractic and Acupuncture will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Outstanding balances due and payable by the 10th of the month. Finance Charge of 1 1/2% per month which is an annual percentage rate of 18% (or minimum \$10.00 per month) will be charged on all past due accounts. If the account is placed for collection, additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions will be added to the amount due. These services and this agreement was entered into the City of Franklin, TN.

Signature Physician: _____ Signature Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case; and I further authorize him to disclose all or any part of my (patient's) record to any person or corporation which is or may be. Liable under a contract to the clinic or the patient or to a family member or employer of the patient for all part of the clinic's charge, including and not limited to, hospital or medial services company, companies workers compensation carriers, welfare funds or the patient's employer.

Patient's Signature: _____

Parent's or Guardian's Signature: _____