



MAIN STREET CHIROPRACTIC AND WELLNESS CENTER

6234 S. Main St.
Downers Grove, IL 60516
630.435.6461
www.mainstchiropractic.com

HEALTH HISTORY QUESTIONNAIRE

"It is our purpose to help as many people as possible get well through chiropractic without the use of drugs or surgery."

Date _____

ALL FIELDS ARE REQUIRED

NAME _____ HOME PHONE (____) _____

ADDRESS _____ WORK PHONE (____) _____

CITY _____ STATE _____ ZIP _____ E-MAIL _____

May we e-mail you our monthly newsletter? YES NO

BIRTHDATE _____ AGE _____ SEX M F SS# _____

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS M S D W SPOUSE'S NAME & AGE _____
CIRCLE ONE

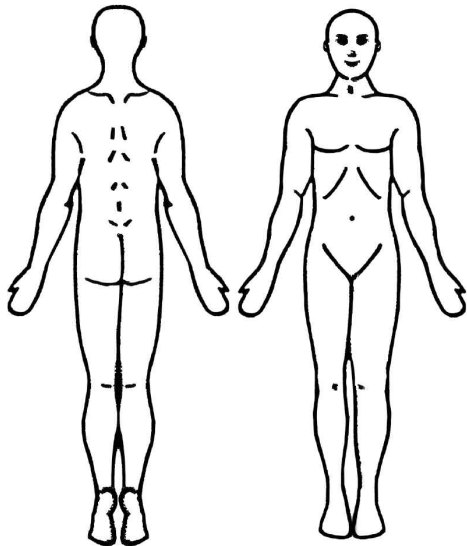
Have you seen a chiropractor before? Y N Last visit date ____/____/____

Most of our patients are referred to our office by a caring family member or friend.

What made you decide to visit our office?

Friend/Family Member NAME _____

Website Sign Presentation E-mail Insurance Website Mailing Newspaper Other



Unwanted Health Condition _____

When did you first notice it? _____

Rate the severity of your pain:

1 2 3 4 5 6 7 8 9 10

Write the letters below on the figures to the left to indicate the type and location of your sensations right now:

A = Ache B = Burning N = Numbness
P = Pins & Needs S = Stabbing O = Other

I agree that Main Street Chiropractic & Wellness Center may print and use my chiropractic success story, copying and distributing it in order to help educate others about the true stories of my success. I am also aware that my testimonial may be selected to be printed in our monthly newsletter and/or other marketing and advertising activities. By signing below, I give permission to have my success story used without having to receive any notice.

Patient Signature

Please answer the following questions to the best of your knowledge

1. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ NEVER
2. When was your last spinal exam, including x-rays? _____ NEVER
3. Have you ever been told that you have vertebral subluxations, spinal curvature, spinal arthritis, or inherited spinal problems? NO YES Please explain _____
4. Subluxation or spinal misalignment can cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head, lower back, or hips? NO YES
5. Spinal misalignments or subluxations can make you feel like you need to twist, stretch, or crack your neck and back. Do you ever feel the need to "crack and pop" your neck or lower spine? NO YES
6. Poor posture leads to poor health, and often indicates spinal problems. How would you rate your posture?

POOR 1 2 3 4 5 6 7 8 9 EXCELLENT

7. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

LOW 1 2 3 4 5 6 7 8 9 HIGH

8. Chiropractic care is for optimal health and healing. However, most of our patients first seek our help when in a health crisis. What health concerns or crises brought you to our office?

1. _____ 2. _____ 3. _____

9. Prescription medications may cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. What medications are you currently taking? _____

10. Auto- and work-related injuries can cause serious spinal problems (even if not reported).

When was your last accident? _____

11. Spinal health is especially important during pregnancy. Is there any chance you are pregnant? YES NO

12. If the doctor feels that chiropractic care will help you, are you willing to follow his recommendations? YES NO

13. Although most health insurance is for emergency care rather than health care, many companies offer chiropractic Benefits. Do you have insurance that you believe will contribute to your chiropractic expenses? YES NO

Name of insurance company _____

14. Many people with spinal problems experience health crises before seeking chiropractic care. Have you had any major hospitalizations or surgeries that the doctor should know about? YES NO

If yes, please explain: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions *must* be answered carefully, as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE: |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you been tested HIV positive? YES NO

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM CODE

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

FEMALES ONLY:

When was your last period? _____

Are you pregnant? Y N

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems: _____

AUTHORIZATIONS

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this 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 products or professional services rendered will be immediately due and payable.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____