

# Conway Chiropractic Center

1238 Pine Street – Conway, South Carolina 29526 - 843.248.5814

**CONFIDENTIAL**  
**PATIENT QUESTIONNAIRE**

<b>Personal Information</b>	Name _____ Date _____
	Address _____ City _____ St _____ Zip _____
	Email _____ Phone(Home) _____
	Age ____ Date of Birth _____ Phone(Work) _____ Ext# _____
	Marital Status <u>  </u> <u>  </u> <u>  </u> <u>  </u> # of Children _____ Social Security # _____
	Occupation _____ Employer Name _____
	Drivers License # _____ State _____
	Name of Spouse _____ Employer of Spouse _____
	Name of Nearest Relative _____ Phone _____
How did you learn about us? _____	

<b>Financial &amp; Insurance Information</b>	Name of party responsible for payment _____
	Drivers License # _____ State _____
	Do you Have Insurance? <u>  </u> <u>  </u> <u>  </u> Company _____
	<b>Insured's name</b> _____ <b>Policy #</b> _____ <b>Group Plan #</b> _____
	<b>Insured's address if different</b> _____ <b>City</b> _____ <b>State</b> _____ <b>Zip</b> _____
	<b>Insured's Date of Birth</b> _____ <b>Social Security #</b> _____

<b>Current Complaint Section</b>	Describe Complaint: _____
	_____
	_____
	At the time of this current complaint, were you under any medically prescribed disabilities or self imposed restrictions? <u>  </u> <u>  </u> <u>  </u> (Describe) _____
	_____

<b>Other Medical Care</b>	List any other doctors seen for this condition (include address).	
	Doctors Name	Address
	Doctors Name	Address
	Doctors Name	Address
	Did you go to the hospital? <input type="checkbox"/> Y <input type="checkbox"/> N	
	If Yes, how did you get to the hospital? <input type="checkbox"/> Ambulance <input type="checkbox"/> Other _____	
	If admitted to hospital, how long did you stay and name of hospital? _____	
	What type of treatment did you receive? (Include recommendation, x-ray, etc.) _____	
Medication prescribed? <input type="checkbox"/> Y <input type="checkbox"/> N List _____		

<b>General Health History</b>	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Stroke
	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness	<input type="checkbox"/> Ulcers
	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Tingling	<input type="checkbox"/> Asthma
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Concussion	<input type="checkbox"/> Anemia	
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Back Problems	
	<input type="checkbox"/> Migraine	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic/Scarlet Fever	
	<input type="checkbox"/> Sinus History	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease	
	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Psoriasis		
If Female, are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Not Certain				
Any prior hospitalization or surgery?				
(list) _____				

<b>Present Complaints</b>	<input type="checkbox"/> Headache	<input type="checkbox"/> Neck Pain/Stiff	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Nausea	
	<input type="checkbox"/> Concentration Loss	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eye Sensitive to Light	
	<input type="checkbox"/> Irritable	<input type="checkbox"/> Neck Motion Restricted	<input type="checkbox"/> Numbness(____)	<input type="checkbox"/> Memory Loss	
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Upper Back Pain/Stiff	<input type="checkbox"/> Swelling(____)	<input type="checkbox"/> Heavy Feeling of Head	
	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Mid Back Pain/Stiff	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Digestive Trouble	
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Low Back Pain/Stiff	<input type="checkbox"/> Depression	<input type="checkbox"/> Cold Feet	
	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Right/Left Shoulder Pain	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Loss of Consciousness	
	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Right/Left Arm Pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cuts(_____)	
	<input type="checkbox"/> Loss of Smell/Taste	<input type="checkbox"/> Flushed Face	<input type="checkbox"/> Bleeding(_____)	<input type="checkbox"/> Nervousness	
	<input type="checkbox"/> Right/Left Leg Pain	<input type="checkbox"/> Pale Face	<input type="checkbox"/> Broken Bones(____)	<input type="checkbox"/> Palpitation	
	<input type="checkbox"/> Pain Behind Eyes	<input type="checkbox"/> Pins & Needles Arms/legs	<input type="checkbox"/> Excess Perspiration	<input type="checkbox"/> Bruises(_____)	
	<input type="checkbox"/> Intolerance to Alcohol	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Jaw Pain	
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other(_____)	
	Radiation of Pain Info      Rt. Arm      Left Arm      Both      Rt. Leg      Left Leg      Both				
	Aggravation of Pain Upon      Walking      Sitting      Standing      Bending      Riding      Lying down				

<b>Pre-Existing Conditions</b>	Have you sought care for a health condition in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Past 2 years <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what condition? _____
	Was treatment administered? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____
	Do you take medication? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____

**COMPLETE THIS SECTION IF DUE TO AN ACCIDENT**

<b>Accident History</b>	Type of accident? <input type="checkbox"/> Auto <input type="checkbox"/> Fall Other _____
	Date of accident _____ Brief description of accident: _____
	_____
	_____

**IF AUTO ACCIDENT COMPLETE BELOW**

<b>(Auto Section)</b>	Were seat belts worn? <input type="checkbox"/> Yes <input type="checkbox"/> No
	List(seat) position in vehicle _____
	If vehicle had headrests, describe the position compared to your head <input type="checkbox"/> Top of headrest aligned with top of head <input type="checkbox"/> Top of headrest aligned with middle of head <input type="checkbox"/> Top of headrest aligned with bottom of head
	Briefly describe the impact collision. <input type="checkbox"/> Head on collision <input type="checkbox"/> Left side impact <input type="checkbox"/> Right side impact <input type="checkbox"/> Rear end collision
	List any part of your body that made contact with vehicle parts _____
	Were you braced for impact? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
	Were brakes applied? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
	Were you looking up into inside rear view mirror? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
	Were you looking at outside door mirror? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
	Was your car stopped? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
	Any previous motor vehicle accidents? <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____ Describe _____
	If yes, was treatment rendered previously? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe _____