

Survey Location _____ Date _____ Appointment Date _____ Time _____

HEALTH SURVEY

Name _____ Place of Employment _____

Address _____ City _____ St _____ Zip _____

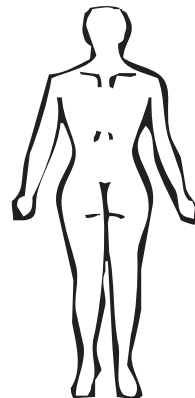
Home Phone _____ Wk Phone _____ Cell _____

E-Mail _____ Date of Birth _____ Age _____

1. PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED IN THE LAST 2 MONTHS

- | | | | |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Leg/Hip Pain | Numbness/Tingling
Chronic Pain
Fibromyalgia
Osteoarthritis |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Shoulder Pain | |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Wrist Pain | |
| <input type="checkbox"/> Whiplash | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Pain w/ Activity | |

Which of these symptoms is the worse _____
 How long have you had it _____
 How often does it occur _____
 How does it feel at its worst? Circle One: No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain



How does it affect you at it's worst?
 No Effect
 Moody
 Irritable
 Interrupts Sleep
 Restricts Daily Activities
 Restricts Recreational Activities
 Decreases Work Productivity
 Other _____

How important is it to you to eliminate this problem?
 Circle One: Not Important 1 2 3 4 5 6 7 8 9 10 Very Important

Are You Pregnant? Yes No

Please circle your areas of pain on the figure

After your initial free in-office evaluation, exam & x-rays, you may choose one additional free service to be done on the next visit :
 Aqua Sooth Massage/Roller Table Personal Training Consult Pilates Consult Cholesterol Screening

2. HAVE YOU EVER HAD ANY INJURIES OR ACCIDENTS

Auto (mo/yr) _____ Work (mo/yr) _____ Other (mo/yr) _____

If yes, please give details of accident _____

3. WHAT TYPE OF DOCTORS ARE YOU CURRENTLY SEEING?

<input type="checkbox"/> Medical Doctor	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Hospital
Last Visit _____	Last Visit _____	Last Visit _____	Last Visit _____

4. HEALTH INSURANCE INFORMATION. THIS HELPS KEEP US INFORMED OF TYPES OF INSURANCE BEING USED

Do You have Insurance? Yes No; If yes, HMO or PPO or Other _____, Name of Insurance Co. _____

PRIVACY PLEDGE AND AUTHORIZATIONS

We are very concerned with protecting your privacy. We understand and will respect the privacy of your health information. The information provided on this survey will NOT be disclosed to ANY OTHER facility, company or organization. From time to time our practice would like to inform you of any special products or special services being offered by us. We may mail information to you or call you to let you know of these special offers. You have the right to deny this service by not signing below.

If you would like for us to call you, please sign and date below. This will expire seven years after the date signed.

Print Name _____ Date _____

Signature _____