Poirier Chiropractic
Family Health Center,P.C.

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HEALTH QUESTIONNAIRE

Date: _____

Name: _____ DOB: _____ SS#: _____

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

Home Ph: (____)_____ Cell Ph: (____)_____ Work Ph: (____)_____

□ Married □ Single □ Widowed □ Divorced Number of Children: _____ Referred By: _____

What are your child / children's names? _____

Occupation: _____ Employer: _____

Would you like to receive our monthly newsletter by email? It includes great tips on leading a healthy lifestyle, updates on events in the office and our monthly calendar. Email: _____

Do you have health insurance or are you on Medicare: □ No □Yes Company_____

Subscriber's Name: _____

Relationship to subscriber: _____ Subscriber's Birthdate: _____

Is it possible that you are or could be pregnant? □ No □ Yes _____

Have you had Chiropractic care before? □No □Yes Where/When? _____

Have you had x-rays, CAT scans, or an MRI of your spine in the last year? □No □Yes _____

Is this condition due to a(n): □Auto Accident □Work Injury □Other accident □Illness □Unknown Cause

Date Symptoms Appeared _____ If accident, please describe what happened: _____

_____

_____

Why are you here today?

_____

_____

_____

_____

_____

_____

Patient Name: _____Date: _____ Pt #_____
Date of Loss: _____ Claim #: _____

Past History

Your past history can affect your present health. Please check all that apply:

☐Falls/accidents ☐Head injuries ☐Fights ☐Sports injuries ☐Broken bones
☐Dislocations ☐Spinal tap ☐Surgery ☐Traction ☐Use(d) cane/walker
☐Extensive dental work ☐Dental appliances ☐Knocked unconscious ☐Pain management injections
☐Osteopenia/Osteoporosis ☐Hospital Stays

If yes to any of the above please describe below:

	Type of accident	Month/Year	Describe injuries
Falls, auto accidents, injuries, or broken bones?			

	Type of surgery	Month/Year	Comments
Surgeries			

	Name of Drug	Doses per day	Length of time taking
Are you presently taking medication or vitamins? ☐Yes ☐No			

Please check any of the following that you have had or are currently dealing with.

☐Headaches
☐Shooting head pains
☐Sinus trouble
☐Loss of smell
☐Allergies
☐Hayfever
☐Asthma
☐Loss of taste
☐Inflammation of throat
☐Thyroid trouble
☐Twitching of face
☐Loss of memory
☐Fatigue
☐Depression
☐Dizziness
☐Spinal Curvature
☐Bed wetting
☐Fainting
☐Loss of balance
☐Ringing in ears
☐Blurred vision
☐Light bothers eyes
☐Neck pain
☐Muscle spasms in neck
☐Grinding in neck
☐Tight shoulders and arms
☐Pain Shoulders & arms
☐Pins & needles arms & hands
☐TMJ Syndrome
☐Numbness in arms/hands
☐Cold hands/fingers
☐Tonsillitis
☐Prostate trouble
☐Heart murmurs
☐Shortness of breath
☐Mid-back pain
☐Heart attacks
☐High blood pressure
☐Low blood pressure
☐Anemia
☐Stomach trouble
☐Nerves and Nervousness
☐Difficulty urinating
☐Irritability
☐Gallbladder trouble
☐Indigestion
☐Intestinal gas
☐Low back pain
☐Hernia
☐Stroke
☐Emphysema
☐Ulcers
☐Numbness legs or feet
☐Constipation
☐Kidney trouble
☐Menstrual cramps/pain
☐Menstrual irregularity
☐Diabetes
☐Sleeping problems
☐Painful Joints
☐Swollen joints
☐Pins & needles in legs
☐Swollen Ankles
☐Cold feet
☐Pain in legs and feet
☐Hip pain
☐Chest pain
☐Pneumonia

Patient Name: _____Date: _____ Pt #_____
Date of Loss: _____ Claim #: _____

What do you know about Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress / subluxation is? ☐Yes ☐No If yes, please describe _____

_____

Are you seeking chiropractic care for: ☐Health maintenance/optimization ☐Health problems ☐Both

Terms of Acceptance

We do not offer to diagnose or treat medically related diseases or conditions other than the Vertebral Subluxation. However, if during the course of the chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis, or treatment for any of those findings, we recommend that you seek the services of a health care provider that specializes in that area. Regardless of what the disease is called we do not offer to treat it. OUR PRACTICE OBJECTIVE IS TO ELIMNATE THE VERTEBRAL SUBLUXATION AND INTERFERENCE TO THE BODY'S IN-BORN HEALTH POTENTIAL AND ADAPTATION CAPABILITIES. OUR METHODS OF CARE FOLLOW THE CHIROPRACTIC PARADIGM OF HEALTH AND ARE TO CORRECT THE VERTEBRAL SUBLUXATIONS COMPLEX AND FASCILITATE COMPLETE NEUROLOGICAL FUNCTION.

The statements made on this form are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Witness: _____

Doctors Notes: