

Infinity Chiropractic

& Wellness Center

170 Hwy 35 Red Bank, NJ 07701

(732) 741-5772

HEALTH QUESTIONNAIRE

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

LAST NAME		FIRST NAME		M.I.	E-MAIL ADDRESS		DATE
ADDRESS				CITY		STATE	ZIP
HOME PHONE		WORK PHONE		ALT. PHONE		DATE OF BIRTH	AGE
EMPLOYER			OCCUPATION		SOCIAL SECURITY NUMBER		
<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	NO. OF CHILDREN		REFERRED BY:			
<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED						
Have YOU had CHIROPRACTIC CARE BEFORE?				YES or NO (Please Circle)			
If So: WHERE?				HOW LONG AGO?			
Do YOU have HEALTH INSURANCE?				YES or NO (Please Circle)			
Company:		Policy #		Group#			
PLEASE INDICATE IF YOU ARE HERE BECAUSE OF AN:						IF SO: Date of Injury	
<input type="checkbox"/> Auto Accident						<input type="checkbox"/> On the Job Injury	
WHAT IS YOUR MAJOR COMPLAINT?							
HOW LONG HAS IT BEEN BOTHERING YOU?				HAS IT BOTHERED YOU BEFORE?		HOW LONG AGO?	
(1-6) PAST HISTORY		MONTH/YEAR INJURY OR SURGERY		TYPE OF INJURY/SURGERY		DESCRIBE INJURY	
HAVE YOU HAD ANY FALLS, AUTO ACCIDENTS, INJURIES, OR SURGERIES?							
IF YES, PLEASE DESCRIBE IN BOXES TO THE RIGHT							
DO YOU TAKE ANY?		TYPE AND DOSES					
(7) PRESCRIBED MEDICATIONS?							
(8) VITAMINS?							
(9) HERBS?							

PLEASE TURN OVER

Please indicate if you have or have had any of the following: Write "C" for current problem, "P" for past problem:

- | | | |
|---|--|--|
| 10. <input type="checkbox"/> Headaches | 28. <input type="checkbox"/> Sleeping problems | 45. <input type="checkbox"/> Indigestion/reflux |
| 11. <input type="checkbox"/> Sinus trouble | 29. <input type="checkbox"/> Diarrhea | 46. <input type="checkbox"/> Intestinal gas |
| 12. <input type="checkbox"/> Loss of smell | 30. <input type="checkbox"/> Constipation | 47. <input type="checkbox"/> Ulcers |
| 13. <input type="checkbox"/> Allergies | 31. <input type="checkbox"/> Incontinence | 48. <input type="checkbox"/> Low back pain |
| 14. <input type="checkbox"/> Hay fever | 32. <input type="checkbox"/> Neck pain | 49. <input type="checkbox"/> Leg pain |
| 15. <input type="checkbox"/> Loss of taste | 33. <input type="checkbox"/> Muscle spasms in neck | 50. <input type="checkbox"/> Hip pain |
| 16. <input type="checkbox"/> Inflammation of throat | 34. <input type="checkbox"/> Grinding/Grating sounds in neck | 51. <input type="checkbox"/> Pins/needles and/or
numbness in legs |
| 17. <input type="checkbox"/> Twitching of face | 35. <input type="checkbox"/> Shoulder pain/tightness | 52. <input type="checkbox"/> Painful joints |
| 18. <input type="checkbox"/> Loss of memory | 36. <input type="checkbox"/> Arm pain/tightness | 53. <input type="checkbox"/> Swollen joints |
| 19. <input type="checkbox"/> Dizziness | 37. <input type="checkbox"/> Pins/needles and/or numbness in
shoulders and arms | 54. <input type="checkbox"/> Swollen ankles |
| 20. <input type="checkbox"/> Fatigue | 38. <input type="checkbox"/> Cold hands | 55. <input type="checkbox"/> Foot pain |
| 21. <input type="checkbox"/> Depression | 39. <input type="checkbox"/> Shortness of breath | 56. <input type="checkbox"/> Cold feet |
| 22. <input type="checkbox"/> Fainting | 40. <input type="checkbox"/> Mid-back pain | 57. <input type="checkbox"/> Menstrual
irregularity/cramps |
| 23. <input type="checkbox"/> Ringing in ears | 41. <input type="checkbox"/> Stomach trouble | 58. <input type="checkbox"/> Other _____ |
| 24. <input type="checkbox"/> Loss of balance | 42. <input type="checkbox"/> Anxiety | 59. <input type="checkbox"/> Other _____ |
| 25. <input type="checkbox"/> Visual disturbances | 43. <input type="checkbox"/> Inner tension | 60. <input type="checkbox"/> Other _____ |
| 26. <input type="checkbox"/> Lights bother eyes | 44. <input type="checkbox"/> Irritability | |

61. Do you smoke? No or Yes (amount) _____

62. Alcohol Intake: _____ beer(s) /Liquor / wine PER day / week / month / year. (Please circle)

63. Females: Are you pregnant? Yes No Not sure (Please circle)

Please indicate if you or a family member has had any of the following: Write "S" for self, "F" for family member:

- | | | |
|---|--|--|
| 64. <input type="checkbox"/> Heart Disease | 67. <input type="checkbox"/> Diabetes | 70. <input type="checkbox"/> Stroke |
| 65. <input type="checkbox"/> Cancer | 68. <input type="checkbox"/> High/Low blood pressure | 71. <input type="checkbox"/> Asthma |
| 66. <input type="checkbox"/> Gastrointestinal Disease | 69. <input type="checkbox"/> Memory/mood disorder | 72. <input type="checkbox"/> Thyroid problem |

The purpose of this office is to provide society with a form of health care
that concerns itself with the true cause of **DIS-EASE**.

This health care is called **CHIROPRACTIC**.

The purpose of Chiropractic is to enable the individual to express 100% of his/her potential.

I fully understand that I am directly responsible to said doctors for all chiropractic bills for services rendered.

I hereby authorize my insurance company to pay directly to Infinity Chiropractic & Wellness Center the benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner any balance if said professional service charges are over and above this insurance payment. It is understood and agreed that the amount paid for x-rays is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office.

Patient's/Guardian's Signature

Date

Signature Authorizing Care

Date