Current Condition Questionnaire

Please complete all of the following questions to the best of your knowledge. A clear understanding of your current condition will help the doctor treat you more effectively.

Today's date_____

Name_____ **Date of Birth**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone/Evening_____ **Work Phone/Evening**_____

Cell phone: _____ **email**_____

❑ **I would be interested in receiving emails regarding on-site events and Tips of the Week**

1. Which of the following best describes the type of care you are seeking?
   ❑ **Temporary relief** ❑ **Long term correction** ❑ **Not sure/depends**
2. Please check the box which best describes your current marital status:
   ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated**
3. Spouse's name_____ Ages of children_____
4. Your employer _____ Spouse's employer _____
5. Days off from work _____ Referred here by _____
6. Who is responsible for your bill? ❑ **Self** ❑ **Spouse** ❑ **Employer** ❑ **Insurance** ❑ **Other**____
7. How will payment be made? **(Check one answer)** ❑ **Cash** ❑ **Check** ❑ **Credit Card** ❑ **Worker's Comp** ❑ **Health Ins.** ❑ **Auto Ins.** ❑ **Other**____
8. Insurance company name/address _____

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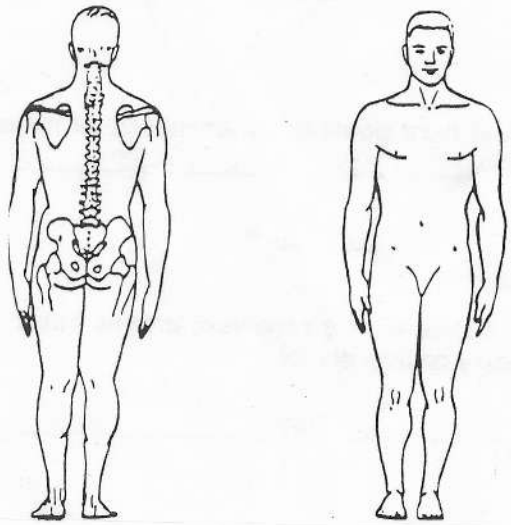
9. Please use the diagram below to mark the exact location of what you are feeling:
   Sharp pain = XXXXX Dull pain = ///////
   Tingling = ::::::: Burning = ZZZZZZ Numbing = oo



MAJOR COMPLAINT

Please describe your major problem, including the type and frequency of the pain:

_____

_____

_____

_____

_____

_____

_____

10. When was the first time you were aware of this problem?_____

11. How do you believe it started? What was the cause?_____

_____

12. Can you think of any accidents, falls, etc. which might have caused your problem? (If "yes", please explain)
_____

13. Did you ever have this problem before? (If "yes", please explain) _____

14. Have you had previous treatment for this condition? (If "yes", please explain) _____

15. Has this problem been getting ❑ **better** ❑ **worse** ❑ **staying the same?**

16. Is there anything you do that makes your condition worse?_____

17. Have you ever been in an auto accident? ❑ **Past yr.** ❑ **Past 5 yrs.** ❑ **Over 5 yrs.** ❑ **Never**

18. Have you ever been treated by a chiropractor before? ❑ **Yes** ❑ **No**

Chiropractor's name and address_____

Dates consulted:_____ For what problem?_____

Activities Discomfort Assessment

Please place a check next to the activity that hurts or you have difficulty performing because of the condition that brought you here today:

Personal Grooming:
_____Combing hair
_____Shaving
_____In/out of bathtub
_____Brushing teeth
_____Other: _____

Housework:
_____Doing laundry
_____Making beds
_____Vacuuming
_____Washing dishes
_____Ironing
_____Carrying groceries
_____Caring for pets
_____Cooking
_____Other:_____

Travel: auto, train truck, airplane
_____Driving
_____As passenger
_____Minutes per day
_____Getting in/out of vehicle

Yardwork:
_____Mowing lawn
_____Shovelling (snow, dirt, mulch)
_____Raking leaves
_____Gardening

General:
_____Walking
_____Standing
_____Running
_____Sitting

General:
_____Lifting children
_____Bending
_____Climbing stairs
_____Reading
_____Sleeping or lying in bed
_____Rolling over in bed
_____Swimming
_____Sports:_____
_____Hobbies:_____
_____Using typewriter or keyboard
_____Kneeling
_____Using telephone
_____Exercising

Besides what you just checked off, do you have other treatment goals or other means of measuring your progress? 1._____ 2._____ 3_____

Fees are payable at the time examinations, x-rays, and treatments are received, unless other arrangements are made in advance. X-rays remain property of this clinic.

Patient's signature_____ Date_____

MOUNT AIRY CHIROPRACTIC CENTER
DAVID E. KORONET, D.C.

PATIENT INFORMATION

PLEASE PRINT

Name _____ Nick Name _____ Date_____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Birth Date _____ Social Security # _____

Sex: M F Martial Status: Single Married Divorced Widowed Other

Full Time Student: YES NO Ages of Children _____

Person responsible for this account _____

Employer Name and Address_____

Employers phone _____

Primary Care Physician Name & Address _____

Primary complaint and problem area _____

Is this a work related injury? YES NO Auto accident injury? YES NO

Email Address _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____
Policy holder's Employer _____
I.D. # _____ Group # _____
Name of Policyholder _____
Policyholder's birth date _____ SS # _____
Relationship to Policyholder _____

PATIENT HEALTH HISTORY

Name: _____

Please check "yes," or "no" for each question, or fill in the answers to the best of your knowledge. These questions are not in any particular order. Your answers will be held in strict confidence.

	Yes	No
Have you gained or lost more than 10 pounds in the past year?	☐	☐
Do you often experience fever or chills?	☐	☐
Do you sometimes have severe soaking sweats at night?	☐	☐
What allergies do you suffer from, if any? _____		None ☐
Have you ever been treated for anemia (thin blood)?	☐	☐
Do you bruise or bleed easily?	☐	☐
Are you currently having a problem with itching or rashes?	☐	☐
Have you ever been treated for a thyroid condition?	☐	☐
Do you have diabetes (sugar disease)?	☐	☐
Does diabetes run in your family?	☐	☐
Have you ever had neck surgery or irradiation treatments?	☐	☐
Do you suffer any disturbance of your vision?	☐	☐
Are you hard of hearing?	☐	☐
Do you have constant noise in your ears?	☐	☐
Do you at times have bad nose bleeds?	☐	☐
Are you often hoarse?	☐	☐
Do you have sinus problems?	☐	☐
Do you have any dental problems?	☐	☐
Do you often have an upset stomach?	☐	☐
Have you ever thrown up blood?	☐	☐
Do you often feel a choking lump in your throat?	☐	☐
Do you suffer from indigestion or heartburn?	☐	☐
Has a doctor ever said you had stomach ulcers?	☐	☐
Do you suffer from frequent loose bowel movements?	☐	☐
Have you ever had bloody diarrhea?	☐	☐
Do you constantly suffer from bad constipation?	☐	☐
What type of hernia do you have, if any? _____		None ☐
Have you ever had piles (rectal hemorrhoids)?	☐	☐
Have you ever had jaundice (yellow eyes and skin)?	☐	☐
Have you ever had liver or gall bladder trouble?	☐	☐
Are you troubled by constant coughing?	☐	☐
Have you ever coughed up blood?	☐	☐
Do you suffer from asthma, wheezing, or shortness of breath?	☐	☐
Have you ever had tuberculosis (TB)?	☐	☐
Have you ever lived with anyone who had tuberculosis (TB)?	☐	☐
Have you ever had a chronic chest condition?	☐	☐
Have you ever smoked in the past, but no longer smoke now?	☐	☐
If you smoke, for how many years? _____ How many packs per day? _____		None ☐
Has a doctor ever said your blood pressure is too high?	☐	☐
Has a doctor ever said your blood pressure is too low?	☐	☐
Does high blood pressure run in your family?	☐	☐
Do you ever have pains in the heart or chest?	☐	☐
Are you often bothered by thumping of the heart?	☐	☐
Do you wear a pacemaker?	☐	☐
Are your ankles often badly swollen?	☐	☐
As a child, did you have rheumatic fever?	☐	☐
Has a doctor ever said you have heart trouble?	☐	☐
Does heart trouble run in your family?	☐	☐
During the day, do you usually have to urinate frequently?	☐	☐
Do you often have severe burning pain when you urinate?	☐	☐

(PLEASE TURN PAGE OVER)

	Yes	No
Have you ever noticed blood in your urine?	☐	☐
Do you sometimes lose control of your bladder?	☐	☐
Do you often wake up at night to urinate?	☐	☐
Were you ever treated for "bad blood" (venereal disease)?	☐	☐
Has a doctor ever said you have a kidney or bladder disease?	☐	☐
Does kidney disease run in your family?	☐	☐
Do you suffer from frequent severe headaches?	☐	☐
Are headaches common in your family?	☐	☐
Do you often have spells of severe dizziness?	☐	☐
Do you frequently feel faint?	☐	☐
Do you have numbness or tingling in any part of your body?	☐	☐
Were you ever knocked unconcious?	☐	☐
Have you ever had a fit or convulsion (epileptic seizure)?	☐	☐
Has anyone in your family ever had epileptic seizures?	☐	☐
Have you ever had a stroke?	☐	☐
Do you suffer from severe rheumatism (arthritis)?	☐	☐
Does rheumatism (arthritis) run in your family?	☐	☐
Have you ever had any fractures or dislocations?	☐	☐
Do you have any metal implants (prosthesis)?	☐	☐
Did a doctor ever treat you for a tumor or cancer?	☐	☐
Does anyone in your immediate family have cancer?	☐	☐
Do you usually sleep fitfully?	☐	☐
Do most days give you a feeling of being stressed?	☐	☐
Do you get shaky if you are hungry?	☐	☐
Do you get irritable before meals?	☐	☐
Do you often leave meals feeling over-full?	☐	☐
Do you have fatigue or a "wiped out" feeling before or after eating?	☐	☐
Do you frequently diet?	☐	☐

What medications are you currently taking, if any? _____
What nutritional supplements are you regularly taking, if any? _____
What surgery have you ever had done, if any? _____
How often do you exercise, if at all? _____ every _____ What type? _____
How many hours do you typically sleep each night? _____ # hours per night
Last doctor seen (type): _____ Date seen: _____ Date of last blood test: _____
Date of last urinalysis: _____ Name of Family Doctor: _____

How many times...	0-1	2-4	5-7	8-10	11+
Per week do you find that you do <u>not</u> eat three balanced meals?	☐	☐	☐	☐	☐
Per week do you eat meals or snacks at fast food restaurants?	☐	☐	☐	☐	☐
Per week do you have meals with green, leafy vegetables?	☐	☐	☐	☐	☐
Per week do you drink soft drinks?	☐	☐	☐	☐	☐
Per week do you add teaspoons of sugar and/or eat candybars?	☐	☐	☐	☐	☐
Per week do you have sweet desserts?	☐	☐	☐	☐	☐
How many cups of coffee do you drink per day?	☐	☐	☐	☐	☐
How many alcoholic drinks do you have per week?	☐	☐	☐	☐	☐

For women only: Have your menstrual periods usually been painful? ☐ Yes ☐ No
Have you often been troubled by vaginal discharge? ☐ Yes ☐ No
What was the date of your last menstrual period? _____
What was the date of your last PAP test? _____
Are you currently using birth control? ☐ Yes ☐ No
(If yes, what type) _____