File # _____
Date: ___/___/___

Health Questionnaire

1 Patient Information

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name _____ **Nickname** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑ Samoan ❑ Guamanian or Chamorro ❑ Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

File # _____
Date: / /

2 How Did You Hear About Us?

___A patient. Please list the patient so that we are able to properly thank the person_____
___A faculty member of Palmer West _____
___A staff member of Palmer West _____
___Yellow Pages ☐ Phone Book ☐ YP Online
___Internet. ☐ Google search ☐ Other, please specify:_____

___Advertisement. Please specify._____
___Sporting Event. Please specify._____

___Facebook or other social media.
___Walk-in.
___VTA Light Rail.
___Palmer Alumni. Please specify._____
___Other. Please specify_____

3 Allergies

Are you allergic to any medication(s)?
❑ Yes ❑ No **If yes, which medications?**
_____

Are you allergic to any of the following?
❑ Bee Sting ❑ Latex ❑ Peanuts ❑ Shellfish
❑ Dairy ❑ Mold ❑ Pollen ❑ Wheat
❑ Eggs ❑ Nuts ❑ Other_____
Describe the reaction:_____

4 Smoking History

Do you currently smoke tobacco of any kind?
❑ Yes ❑ Former smoker ❑ Never been a smoker
If yes, how often do you smoke:
❑ Current every day smoker
❑ Current sometimes smoker
If yes, what is your level of interest in quitting smoking?
❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

5 Medications

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Medication Name	Quantity / Dosage (ie. 1 tablet / 5 mg)	Frequency (ie. 2 times / day)	Start Date
1				
2				
3				
4				
5				
6				

Do you currently use any recreational drugs? ❑ Yes ❑ No [ ] Check here if you take more than 6 medications

File # _____
Date: ___/___/___

Social History

WORK ACTIVITY: What is your job description: _____

What do you do most of the day at work? ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor ❑ Other: _____

What job did you do during most of your life? _____

How would you describe the physical stress level at work? ❑ Low ❑ Medium ❑ High

EDUCATION: Mark the highest level of education completed: ❑ Elementary school ❑ Middle school ❑ High School ❑ Vocational School ❑ GED ❑ Associates Degree ❑ Bachelors Degree ❑ Graduate Degree ❑ Doctorate ❑ other

DIET/NUTRITION

Are you on any special diet? ❑ Yes ❑ No If yes, for what reason? _____

Is your weight a concern for you emotionally or physically? ❑ Yes ❑ No

Have you gained or lost over 10 pounds in the past 6 months without wanting to? ❑ Yes ❑ No

My dietary intake consists mainly of the following: (Mark all that apply)

❑ Fruits ❑ Vegetables ❑ Whole Grains ❑ High Fiber ❑ Low Fiber
❑ High Salt ❑ Low Salt ❑ High Sugar ❑ Low Sugar ❑ Low Carbohydrate
❑ High Fat ❑ Low Saturated Fats ❑ High Protein ❑ Low Calorie

Rate your appetite on the below scale of 1 to 10:

☺Normal Appetite 1 2 3 4 5 6 7 8 9 10 Eat Nothing☹

How many 8 ounce glasses of water do you drink a day? _____

Alcohol Use: Now? ❑ Yes ❑ No Amount/Weekly____ How long? _____ Years/Months
In the past? ❑ Yes ❑ No Amount/Weekly____ How long? _____ Years/Months

How many coffee caffeine drinks do you drink a day? Cups ____ None ____

How many soda caffeine drinks do you drink a day? Cans ____ None ____

Current Vitamins, Minerals, Herbs, etc. List ANY/ALL non-prescription items you are CURRENTLY taking.

	Vitamin, Mineral, Herbs	Quantity / Dosage (ie. 1 tablet / 5 mg)	Frequency (ie. 2 times / day)	Start Date
1				
2				
3				
4				
5				
6				

Health Review

How many hours of sleep are you getting per night? ❑ Less than 5 ❑ 6-8 ❑ 8-10 ❑ 10 or more hours

How would you rate your sleep on the following scale? ☺Wake-up Fully Rested 0 1 2 3 4 5 6 7 8 9 10 No/Poor Sleep☹

How many days a week do you exercise for 30 minutes or more? ❑ 0 ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7

How would you rate the intensity of your exercise? ☺High Intensity 0 1 2 3 4 5 6 7 8 9 10 No Exercise☹

How would you rate your physical stress level? ☺No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed☹

How would you rate your emotional stress level? ☺No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed☹

List your major stressors: _____

What are you health goals? _____

In addition, talk to your doctor about other areas which may be affecting your health-such as worries about finances, social support, and alcohol, tobacco and/or drug use.

File # _____
Date: / /

1 Personal Health History

Are your currently under the care of a Healthcare Provider or any other doctor? ❑ Yes ❑ No
If yes, for what condition(s)_____
_____
Provider's Name _____ Phone Number_____
Has any doctor diagnosed you with Hypertension recently? ❑ Yes ❑ No
If yes, describe: _____
Has any doctor diagnosed you with Diabetes recently? ❑ Yes ❑ No
If yes, was your blood lab-work test for hemoglobin A1c >9.0% ❑ Yes ❑ No ❑ Not Sure
If yes, other comments regarding Diabetes: _____
Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Do you wear any of the following? ❑ Heel Lifts ❑ Innersoles ❑ Arch Supports ❑ Orthotics ❑ Other_____
For how long? _____ Were they prescribed by a doctor? ❑ Yes ❑ No
Have you seen a chiropractor in the past? ❑ Yes ❑ No Date of last visit_____
If yes, name and location of previous Chiropractor_____ Phone Number_____
Were you satisfied with your care? ❑ Yes ❑ No Why? _____

Date of last:				
	Chiropractic Exam		Prostate/PSA	
	Cholesterol		Mammogram	
	MRI		Pap Smear	
	CT-Scan		Colon	
	Spinal X-ray		Stool check for blood	

Childhood Illnesses:

- ❑ ADD
- ❑ atopic dermatitis
- ❑ allergies/hayfever
- ❑ anemia
- ❑ asthma
- ❑ bedwetting
- ❑ cerebral palsy
- ❑ chicken pox
- ❑ crohn's/colitis
- ❑ depression
- ❑ diabetes
- ❑ ear infections
- ❑ fetal drug exposure
- ❑ headaches
- ❑ hepatitis
- ❑ HIV
- ❑ measles
- ❑ mumps
- ❑ psoriasis
- ❑ rash
- ❑ scoliosis
- ❑ seizures
- ❑ sickle cell
- ❑ spina bifida
- ❑ other:

Immunization:

❑ All recommended vaccines ❑ Not vaccinated

- ❑ adenovirus
- ❑ DTaP(diphtheria,tetanus,pertussis)
- ❑ haemophilus B
- ❑ hepatitis B
- ❑ influenza
- ❑ IPV(polio)
- ❑ MMR(measles,mumps, rubella)
- ❑ pneumococcal
- ❑ rotavirus
- ❑ tetanus
- ❑ varivax(chicken pox)
- ❑ other:_____

Adult Illnesses:

- ❑ ADD
- ❑ Alzheimer's
- ❑ arthritis
- ❑ asthma
- ❑ cancer
- ❑ cerebral palsy
- ❑ chicken pox
- ❑ colitis
- ❑ CRPS(RSD)
- ❑ CVA(stroke)
- ❑ chicken pox
- ❑ cystic kidney disease
- ❑ depression
- ❑ diabetes
- ❑ eczema
- ❑ emphysema
- ❑ eye problems
- ❑ fibromyalgia
- ❑ heart disease
- ❑ hepatitis
- ❑ HIV
- ❑ high blood pressure
- ❑ influenza pneumonia
- ❑ liver disease
- ❑ lung disease
- ❑ lupus erythema
- ❑ multiple sclerosis
- ❑ Parkinson Disease
- ❑ unspecified pleural effusion
- ❑ pneumonia
- ❑ psoriasis
- ❑ psychiatric condition
- ❑ scoliosis
- ❑ seizures
- ❑ shingles
- ❑ STD's (unspecified)
- ❑ suicide attempt(s)
- ❑ thyroid problems
- ❑ vertigo
- ❑ Other: _____

Injuries: (List date next to injury)

- ❑ back injury
- ❑ broken bones
- ❑ disability (ies)
- ❑ fall (severe)
- ❑ fracture
- ❑ head injury
- ❑ industrial accident
- ❑ joint injury
- ❑ laceration (severe)
- ❑ motor vehicle accident
- ❑ soft tissue injury
- ❑ Other:_____

File # _____
Date: / /

Surgeries:

	Date	Procedure (e.g. knee repair)	Description	
1				In Patient/Out Patient
2				In Patient/Out Patient
3				In Patient/Out Patient
4				In Patient/Out Patient
5				In Patient/Out Patient

Review of Systems

Please indicate if you have any of the following by checking the box.

Constitutional	❑ None ❑ chills	❑ daytime drowsiness ❑ fatigue	❑ fever ❑ loss of appetite	❑ night sweats ❑ weight gain / loss
Eyes/Vision	❑ None ❑ blindness ❑ blind spots	❑ cataracts ❑ double vision ❑ eye problems	❑ itching ❑ photophobia ❑ tearing	❑ wears contacts/glasses
Ears, Nose & Throat	❑ None ❑ dizziness ❑ ear discharge ❑ ear pain	❑ fainting ❑ frequent sore throats ❑ headaches ❑ hearing loss	❑ history of head injury ❑ loss of sense of smell ❑ nosebleeds ❑ nasal congestion	❑ runny nose ❑ sinus infection
Respiration	❑ None ❑ asthma	❑ cough ❑ coughing up blood	❑ shortness of breath ❑ sputum production	❑ wheezing
Cardiovascular	❑ None ❑ claudication (leg pain and ache) ❑ heart problem ❑ heart murmur	❑ high blood pressure ❑ low blood pressure ❑ orthopnea(difficulty breathing lying down) ❑ palpitations	❑ paroxysmal nocturnal dyspnea ❑ shortness of breath with exertion ❑ ulcers	❑ varicose veins
Gastrointestinal	❑ None ❑ abdominal pain ❑ abnormal stool (Color/consistency)	❑ belching ❑ black/tarry stool ❑ constipation ❑ diarrhea	❑ difficulty swallowing ❑ heartburn ❑ hemorrhoids ❑ indigestion	❑ jaundice ❑ ulcers ❑ rectal bleeding
Female	❑ None/Not Applicable ❑ abnormal vaginal Bleeding	❑ birth control ❑ breast lump/pain ❑ burning urination ❑ cramps	❑ frequent urination ❑ hormone therapy ❑ irregular menstruation ❑ urine retention	❑ vaginal discharge
	I ... ❑ am currently pregnant I ... ❑ currently have menses		❑ am NOT currently pregnant ❑ currently DO NOT have menses	
	My menses... ❑ are regular _____age of first menses Date of last menstrual period ____/____/____		❑ are NOT regular _____age when menopause began	
	If you have been pregnant in the past, please fill in the appropriate information below. _____Number of complicated pregnancies _____Number of C-sections _____Number of miscarriages		_____Number of uncomplicated pregnancies _____Number of vaginal deliveries _____Number of terminated pregnancies	
	Do you have any concerns about your sexual health? ❑ Yes ❑ No Are you or have you ever been a victim of domestic or sexual abuse? ❑ Yes ❑ No			
Male	❑ None/Not Applicable	❑ burning urination ❑ erectile dysfunction	❑ frequent urination ❑ hesitancy/dribbling	❑ prostate problems ❑ urine retention
	Do you have any concerns about your sexual health? ❑ Yes ❑ No Are you or have you ever been a victim of domestic or sexual abuse? ❑ Yes ❑ No			

File # _____

Date: / /

Endocrine	❑ None ❑ cold intolerance ❑ diabetes	❑ excessive appetite ❑ excessive hunger ❑ excessive thirst	❑ goiter ❑ hair loss ❑ heat intolerance	❑ unusual hair growth ❑ voice changes
Skin	❑ None ❑ change in nail texture	❑ change in skin color ❑ hair loss ❑ hives	❑ history of skin disorders ❑ itching ❑ numbness	❑ rash ❑ skin lesions/ulcers ❑ varicosities
Nervous System	❑ None ❑ dizziness ❑ facial weakness ❑ headache	❑ limb weakness ❑ loss of consciousness ❑ loss of memory ❑ numbness	❑ seizures ❑ sleeps disturbance ❑ slurred speech ❑ stress	❑ stroke ❑ unsteadiness of gait/loss of balance
Psychological	❑ None ❑ anxiety ❑ behavioral change	❑ bi-polar disorder ❑ confusion ❑ convulsions	❑ depression ❑ insomnia ❑ loss or change of appetite	❑ memory loss ❑ mood change
Hematologic	❑ None ❑ anemia	❑ bleeding ❑ blood clotting	❑ blood transfusion ❑ bruising easily	❑ fatigue ❑ lymph node swelling

8 Family History

Relation	Age (now or at death)			Serious illness/cause of death
Father		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Paternal grandfather		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Paternal grandmother		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Mother		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Maternal grandfather		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Maternal grandmother		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Brother(s)		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Sister(s)		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Son(s)		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Daughter(s)		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	

File # _____
Date: / /

9 Patient Condition

Reason(s) for visit:_____

Is this condition due to an accident? ❑ Yes ❑ No ❑ Auto ❑ Work ❑ Home ❑ Other Date_____

What was the mechanism of accident/injury?_____

When did your symptoms appear?_____ Is this condition getting worse? ❑ Yes ❑ No

How often do you have this problem? _____ Is it constant or does it come and go?_____

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are difficult / painful to perform:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Circle your pain on the below scale of 0 to 10:

(at rest) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

(with activity) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

What treatment have you already received for your condition?

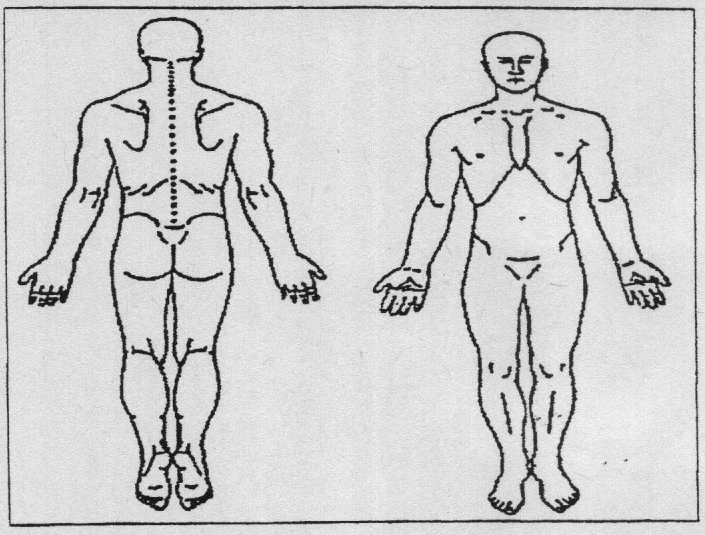
❑ Medications ❑ Surgery ❑ None ❑ Physical Therapy ❑ Chiropractic Care

Name of other doctor(s) who have treated you for this condition_____

_____

Were you satisfied with the results of your treatment? ❑ Yes ❑ No Explain_____

Mark an "X" on the picture where you continue to have pain, numbness or tingling.



While we will work closely with you to resolve your chief complaint, as health professionals we are also concerned about your overall wellness. On future visits we will discuss issues with you that may impact your overall health.

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at the Palmer Clinics at this time.

_____

Patient Signature Date

_____

Signature of Parent or Legal Guardian Relationship

Please answer all of the following questions to help us determine possible risk factors:

QUESTION	YES	NO	DOCTOR'S COMMENTS
GENERAL			
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	❑	❑	
BONE WEAKNESS (OSTEOPOROSIS)			
Have you been diagnosed with osteoporosis?	❑	❑	
Do you take corticosteroids (e.g. prednisone)?	❑	❑	
Have you been diagnosed with compression fracture(s) of the spine?	❑	❑	
Have you ever been diagnosed with cancer?	❑	❑	
Do you have any metal implants?	❑	❑	
VASCULAR CONCERNS			
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	❑	❑	
Have you ever had a stroke or TIA (transient ischemic attack)?	❑	❑	
If you have a complaint of neck pain or headache, does this pain seem unlike anything you have experienced before?	❑	❑	
Have you ever been diagnosed with any of the following disorders/diseases?			
• Rheumatoid arthritis	❑	❑	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	❑	❑	
• Giant cell arteritis (temporal arteritis)	❑	❑	
• Osteogenesis imperfecta	❑	❑	
• Ligamentous hypermobility such as with Marfan's Disease, Ehlers-Danlos Syndrome	❑	❑	
• Medial cystic necrosis (cystic mucoid degeneration)	❑	❑	
• Bechet's disease	❑	❑	
• Fibromuscular dysplasia	❑	❑	
Have you ever become dizzy or lost consciousness when turning your head?	❑	❑	
SPINAL COMPROMISE OR INSTABILITY			
Have you had spinal surgery?	❑	❑	
If yes, when? _____			
Have you been diagnosed with spinal stenosis?	❑	❑	
Have you had any of the following problems?			
• Sudden weakness in the arms or legs?	❑	❑	
• Numbness in the genital area?	❑	❑	
• Recent inability to urinate or lack of control when urinating?	❑	❑	

I have read the previous information regarding risks of chiropractic care and my clinician has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____
(if appropriate)

DOCTOR'S SIGNATURE _____ DATE _____

Anderson Chiropractic Health Center Office Policies

Welcome to our clinic! We believe that communication regarding our policies helps us to provide the best service to you, and allows you to feel more comfortable about our procedures. It is our mission to provide you with the highest standard of care and help you to quickly meet your health goals. To this end we ask that you take an active role in your care, and kindly comply with the office policies, which help us to provide the best care for each patient. Please know that we will do our best to accommodate special needs, and answer any questions you may have.

Our office forms will be sent to you via email, prior to your appointment and must be completed and brought with you to your appointment. If your forms are not completed in full , you will be charged a missed appointment fee and rescheduled. Should you not be able to print the forms, or complete them online, please arrive 15 min before your scheduled appointment time.

Financial Policy:

Payments are due at the time of service. When provided with the necessary information, we will bill your Insurance Company. Joanne Queiroz at Chirobill will be happy to answer questions and address any billing concerns. Her number is 925-706-9884 or you can email her at joanne@chirobill.com. Special needs are understood in our office, and we will try to accommodate them when possible.

Initials: X_____

Appointments and Cancellations:

Dr. Anderson's schedule allows 20-30 minutes for personal attention to each patient. Initial exam meetings last 30-60 minutes. Often same day appointments are available. Rescheduling or cancellations, which are not received 24 hours before the scheduled appointment will be assessed, and a **$50 fee** for an adjustment, a **$70 fee** for a full treatment and **$150** for new patients for time reserved. Please call Dr. Anderson's cell phone at 408-218-6359 to change or cancel appointments. We will keep a credit card number on file for missed appointments.

Initials: X_____

CC#:_____ Exp date:_____

Authorization Code:_____ Billing Zip:_____

Authorization to Release Information:

I authorize Dr. Anderson to release any information acquired in the course of my treatment to my present Insurance Company, attorney, doctor, and/or dentist. I may request the release of information to any other party upon written request. I understand that if I remove myself from Dr. Anderson's care, I must provide a signed release for her to be able to transfer my records to a new doctor.

Initials: X_____

Payment agreement and Assignment of Benefits:

I understand and agree that I am responsible and liable for all charges assessed and professional service rendered including any fees for rescheduling or cancellation of appointments without 24 hour notice. I understand that any insurance billing is done as a courtesy, and I am responsible for all charges regardless of existing coverage. In addition, I understand that if it becomes necessary for Anderson Chiropractic to commence collection action on my account, I am responsible for all reasonable fees incurred in addition to the outstanding balance.

Initials: X_____

I have read, understood, and agree to the statements and conditions herein contained.

_____ _____

Patient Signature Date