BOYSON CHIROPRACTIC P.C.

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

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED NO. OF CHILDREN	REFERRED BY:
IN CASE OF EMERGENCY, PLEASE CONTACT:	CONTACT PHONE NUMBER:

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#

If different from above: Policy Holder's SSN# -- -- Policy Holder's Birthday:

PLEASE INDICATE IF YOU ARE HERE BECAUSE OF AN: ☐Auto Accident ☐On the Job Injury ☐Other	IF SO: Date of Injury

HOW LONG HAS IT BEEN BOTHERING YOU?	HAS IT BOTHERED YOU BEFORE?	HOW LONG AGO?

HAVE YOU HAD ANY:	TRAUMAS	AUTO ACCIDENTS	SURGERIES
WHEN DID IT OCCUR?			
TYPE OF INJURY?			
WHAT HAPPENED?			
DO YOU TAKE ANY:	TYPE AND DOSES		
PRESCRIBED MEDICATIONS?			
VITAMINS?			
HERBS?			

PLEASE TURN OVER

Hiawatha
1450 Boyson Road, Suite B4
Hiawatha, IA 52233
Phone: (319) 378-0562
Fax: (319) 378-3904

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

__ Headaches
__ Sinus trouble
__ Loss of smell
__ Allergies
__ Hay fever
__ Loss of taste
__ Inflammation of throat
__ Twitching of face
__ Loss of memory
__ Dizziness
__ Fatigue
__ Depression
__ Fainting
__ Ringing in ears
__ Loss of balance
__ Visual disturbances
__ Lights bother eyes
__ Cold sweats
__ Sleeping problems
__ Bowl or bladder troubles
__ Neck pain
__ Muscle spasms in neck
__ Grinding/Grating sounds in neck
__ Shoulder pain/tightness
__ Arm pain/tightness
__ Pins/needles and/or numbness in shoulders and arms
__ Cold hands
__ Shortness of breath
__ Mid-back pain
__ Stomach trouble
__ Anxiety
__ Irritability
__ Indigestion/reflux
__ Intestinal gas
__ Ulcers
__ Low back pain
__ Leg pain
__ Hip pain
__ Pins/needles and/or numbness in legs
__ Painful joints
__ Swollen joints
__ Swollen ankles
__ Foot pain
__ Cold feet
__ Menstrual irregularity/cramps
__ Other_____
__ Other_____
__ Other_____

Do you smoke? No or Yes **(amount)** _____
Alcohol Intake: _____beer(s) /Liquor / wine **PER** day / week / month / year. ***(Please circle)***
Females: Are you pregnant? Yes No Not sure **(*Please circle)***
Males: (Age 40+) Have you had a prostate exam with in the last year? 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:***

__ Heart Disease
__ Cancer
__ Gastrointestinal Disease
__ Diabetes
__ High/Low blood pressure
__ Memory/mood disorder
__ Stroke
__ Asthma
__ Thyroid problem

I hereby authorize my insurance company to pay directly to Boyson Chiropractic, PC the benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance, for all services rendered on my behalf or on the behalf of my dependents. I authorize the above noted clinic and/or any providers or suppliers of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Patient's/Guardian's Signature Date

_____ _____
Signature Authorizing Care Date

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Pain Chart

Pain Representation

Ache
V V V V V V V
V V V V V V

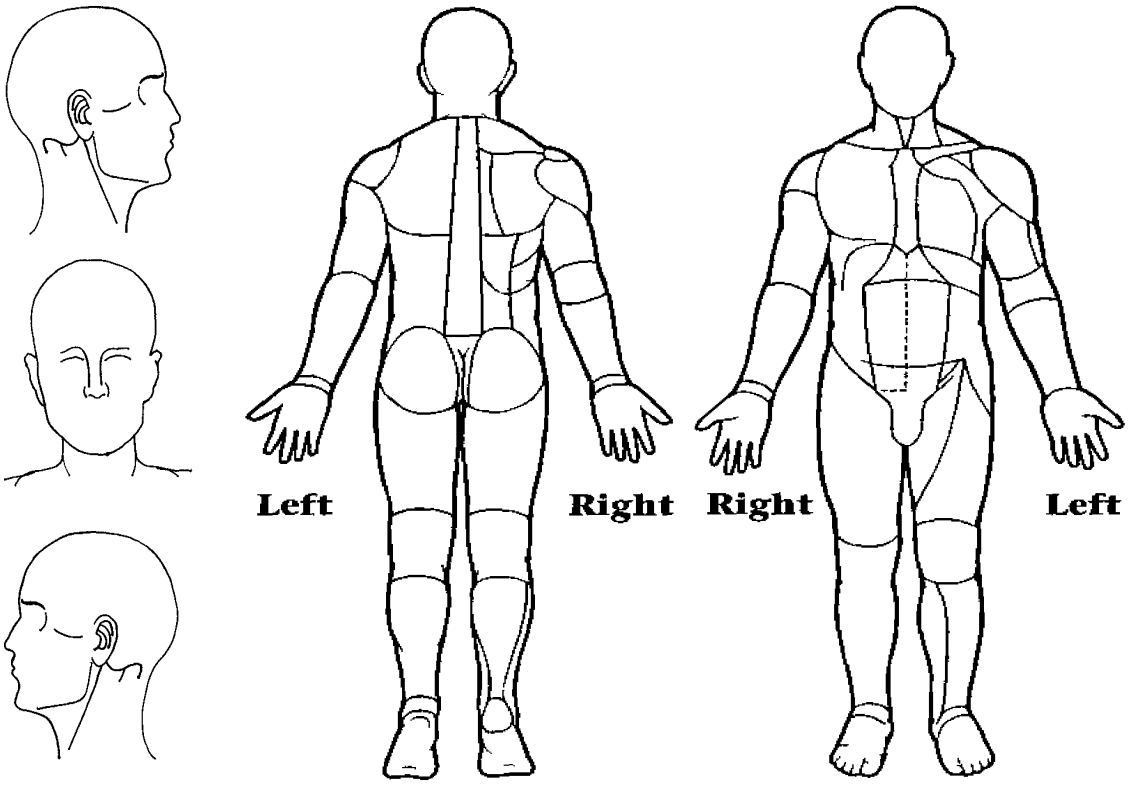
Burning
● ● ● ● ● ● ●
● ● ● ● ● ●

Numbness or Tingling
O O O O O O O O O
O O O O O O O

Stabbing
/ / / / / / / / /
/ / / / / / / /

Other
X X X X X X X
X X X X X X

Draw location and type of pain on the body outline and mark how much pain you are currently in on the line at the bottom of the page.



No Pain **Worst Pain**

Please make a slash through this line to indicate the level of your overall pain.

Signature Date

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