Queens Chiropractic Associates, P.C.
865 Cypress Avenue
Ridgewood, NY 11385
Tel: 718-628-5300 Fax: 718-628-6297

Chiropractic Health Questionnaire

Name:________________________ Social Security #: ________________________

Address:________________________ City: ____________ State: ________ Zip Code: ________

Home Telephone: ________________ Age: ______ Birth Date: __________ Marital Status: M S D W

Work Telephone: ________________ Email Address: ________________________

Cell Telephone: ________________ # of Children __________ Spouses Name: __________

Occupation: ________________ ☐FT ☐PT Referred By: ________________________

What are your complaints? ____

____

How long have you had this condition? __________ Have you had this condition in the past? ☐yes ☐ no

What activities aggravate your condition? ________________________________

Is the condition getting worse? ☐yes ☐no Is the pain: ☐Constant ☐Comes and goes/Occasional

Have you had previous chiropractic care? ☐yes ☐no If yes, doctor ________________________

List surgical operations and years: ____

List of medications you are presently taking: ________________________________

Age of mattress: ________________ Comfortable ☐yes ☐no Uncomfortable ☐yes ☐no

Are you using any of the following? ☐Heel lifts ☐Sole lifts ☐Inner soles ☐Arch supports

Were you ever in an automobile accident? ☐yes ☐no If yes, give dates: ________________

Were you ever injured at work? ☐yes ☐no If yes, give dates: ________________________

Have you had any other personal injuries or accidents? ☐yes ☐no If yes, give dates: ____________

Date of your last physical examination: ______________ Family Doctor: ________________

Qu[illegible]ns Chiropractic Associates, P.C.
865 Cypress Avenue
Ridgewood, NY 11385
Tel: 718-628-5300 Fax: 718-628-6297

Chiropractic Health Questionnaire – Page 2

Have you ever suffered from the following?

☐Dizziness	☐Arthritis	☐Neuritis	☐Sinus Trouble
☐Backaches	☐Headaches	☐Heart Trouble	☐Digestive Disorders
☐Neck Pain	☐Asthma	☐Nervousness	☐Diabetes

Please list any other ailments or conditions: ______________________________

Please list any treatments or physicians you have seen for these conditions: ______________

____

____

Insurance Information

Is your condition due to an auto or job related injury? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐No

If yes, please provide us with the name of your health insurance: ____________________

Policy #: ____________________ Plan Type (HMO/PPO/Senior Plan): ______________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: ______________________________ Date: ______________

Guardian's Signature: ______________________________ Date: ______________