CONFIDENTIAL NEW PATIENT QUESTIONAIRE

PATIENT INFORMATION

How did you hear about our office? _____

LAST NAME _____ FIRST NAME_____ MI_____ TITLE_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE(_____)_____ CELL PHONE: (_____)_____

Date of Birth_____ Age____ e-mail ADDRESS_____

GENDER ☐ M ☐ F SOC SEC No_____-_____-_____ MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

TELL US ABOUT YOUR PAIN/SYMPTOM

DESCRIBE _____

WHAT MAKES IT FEEL WORSE_____

WHAT MAKES IT FEEL BETTER_____

OTHER DOCTORS SEEN FOR THIS_____

_____

WHAT ELSE HAVE YOU DONE TO HELP… HAS IT WORKED _____

_____

DESCRIBE YOUR HEALTH OTHERWISE _____

_____

HOW & WHEN DID IT START

WHEN DID YOUR CONDITION BEGIN _____

HAVE YOU HAD THIS BEFORE _____

WHAT CAUSED YOUR CONDITION _____

IF YOUR CONDITION BEGAN GRADUALLY OVER TIME, ARE YOU AWARE OF THE STRESSORS THAT CONTRIBUTED ___

_____

TELL US ABOUT YOUR DAILY ROUTINE

DESCRIBE YOUR DAILY WEEKDAY (WORK) ACTIVITIES _____

_____

_____

HOW HAS YOUR CONDITION EFFECTED YOUR WEEKDAY/WORK ACTIVTIES _____

_____

DESCRIBE YOUR REGULAR WEEKEND/FUN ACTIVITIES _____

_____

_____

HOW HAS YOUR CONDITION EFFECTED YOUR WEEKEND/FUN ACTIVITIES _____

_____

_____

DESCRIBE YOUR EXERCISE/STRETCHING ROUTINE_____

_____

_____

HAVE YOU USED ORTHOTICS? IF YES, DESCRIBE _____

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TELL US ABOUT YOUR NUTRITION

WE BELIEVE THAT GOOD NUTRITION AND SUPPLEMENTATION IS VITALLY FOR GOOD HEALTH. THIS IS ESPECIALLY WHEN YOU ARE ATTEMPTING TO HEAL. IF YOU BELIEVE THAT THE NUTRITION AND SUPPLEMENT COMPONENT OF YOUR HEALTH IS WELL TAKEN CARE OF, THEN THIS SECTION IS OPTIONAL, EXCEPT FOR QUESTION ONE. IF DESIRED, FEEL FREE TO BRING THIS FORM HOME AND RETURN IT ON YOUR NEXT VISIT.

WHAT MEDICATIONS DO YOU TAKE (ALL) _____

_____

DESCRIBE THE SUPPLEMENTS YOU TAKE ON A REGULAR BASIS _____

_____

_____

DESCRIBE YOUR TYPICAL BREAKFAST, INCLUDING TIME _____

_____

_____

DESCRIBE YOUR TYPICAL LUNCH, INCLUDING TIME _____

_____

_____

_____

DESCRIBE YOUR TYPICAL DINNER, INCLUDING TIME _____

_____

_____

_____

DESCRIBE ANY SNACKS IN A TYPICAL DAY/WEEK, INCLUDING TIME _____

_____

_____

DESCRIBE ANY DIGESTIVE OR HORMONE CHALLENGES YOU HAVE _____

_____

_____

_____

HOW MUCH WATER DO YOU DRINK IN A TYPICAL DAY _____

HOW MUCH CAFFEINE DO YO DRINK IN A TYPICAL DAY _____

DO YOU DRINK ALCOHOL/HOW MUCH/OFTEN _____

DO YOU USE RECREATIONAL DRUGS/WHAT _____

HAVE YOU EVER DONE A (NUTRITIONAL) CLEANSE / DESCRIBE _____

_____

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For your visit today, our focus is to address your primary health concern. However, with your permission, our ultimate goal is to determine the stress that caused your condition in the first place. Stress comes in three dimensions and impacts every aspect of our health.

We have a solution for every dimension of stress.

Physical • Mental/Emotional • Bio-Chemical

Your answers to the following questions will help us to ***Customize our Multiple Therapeutic Solution specifically for you.***

	Symptoms/Activity	MILD				SEVERE
1.	Sit: 0 = 1hr/day, 1 = 2hrs, 2 = 3 hours, 3 = 4 hrs … 4 = 5+ hrs	0	1	2	3	4
2.	Stand: 0 = 1hr/day, 1 = 2hrs, 2 = 3 hours, 3 = 4 hrs … 4 = 5+ hrs	0	1	2	3	4
3.	Sleep face down: 0=Not at All; 4 = All the time	0	1	2	3	4
4.	Concerned about my posture	0	1	2	3	4
5.	Do not Exercise: 0 = Completely Disagree; 4 = Completely Agree	0	1	2	3	4
6.	Been in Motor Vehicle Accidents	0	1	2	3	4
7.	Played contact sports	0	1	2	3	4
8.	Irritable and moody	0	1	2	3	4
9.	Mental fatigue/brain-fog	0	1	2	3	4
10.	Depressed/Anxious	0	1	2	3	4
11.	Sleep issues	0	1	2	3	4
12.	Have “impossible” deadlines/Feel stress a lot	0	1	2	3	4
13.	Persistent headaches	0	1	2	3	4
14.	Eat out a lot	0	1	2	3	4
15.	Eat processed foods – fast-food, boxed/canned food	0	1	2	3	4
16.	Dizziness/faintness	0	1	2	3	4
17.	Eye/muscle twitching	0	1	2	3	4
18.	Allergies	0	1	2	3	4
19.	Acne or other skin conditions	0	1	2	3	4
20.	General overall achiness/fatigue	0	1	2	3	4

Total:

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ASSIGNMENT OF BENEFITS / RIGHTS FOR DIRECT PAYMENT TO DOCTOR

PRIVATE & GROUP ACCIDENT & HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

HOLST CHIROPRACTIC OFFICE
450 EAST MAIN STREET
MIDDLETOWN, NY 10940

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize the release of any information pertinent to my case to any insurance company, adjustor ar attorney involved in this case.

_____ _____
Name of Patient (Please Print) Date

_____ _____
Signature of Patient Signature of Guardian (If Minor)

MEDICARE ASSIGNMENT OF BENEFITS / RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to _____ for services rendered to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Patient Signature Date