Dr. Funn New Patient Questionnaire

Patient Information

Patient I.D. ______________

Please Print

Name______________________________ Date________ SS#__________________

Address______________________ City__________ State________ Zip__________

Seasonal Address______________________ City__________ State_____ Zip__________

☐Male ☐Female ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Birthdate__________ Home Phone__________________ Cell__________________

Work Phone________________ E-mail Address____________________________

Employer____________________ Occupation__________________ #years________

Business Address______________________ City__________ State_____ Zip__________

Spouse or Parent's Name____________ Birthdate__________ Phone______________

Emergency Contact____________ Phone________________ Relation____________

Whom may we thank for referring you to us? ______________________________

Did you see our Newspaper Flyer?_____ Yellow Page Ad? _____ Other?____________

Name of local primary Physician______________________ May we contact them?_____

Insurance Information – *If Insured, Please provide copy of insurance card*

SYMPTOMS

Main Complaint________________________ How Bad?________ How Often?________

When did it start?________________Getting Worse?________Getting Better?________

What activity bothers it the most? ______________________________________

When is it at its best?________________ When is it at its worst?______________

Rate the pain - (0 is pain tree - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?________________ Positive Experience?____________________

Other type of physician or therapist?____________ Positive Experience?____________

Secondary Complaint____

Health History - *Please circle all that apply*

AIDS/ HIV, Allergy Shots, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding
Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts, Chicken pox, Depression, Diabetes
Emphysema, Epilepsy, Fractures, Glaucoma, Goiter, Gonorrhea, Gout, Heart dx
Hepatitis, Hernia, Herniated disc, Herpes, High Cholesterol, Kidney dx, Liver dx, Measles
Migraines, Miscarriage, Mono, M. S., Mumps, Osteoporosis, Parkinson's, Polio
Pacemaker, Pneumonia, Prostate, Prosthesis, Implants, Rheumatoid, Stroke, Thyroid
Tonsillitis, Tuberculosis, Tumors, Typhoid, Ulcers, V. D., Whooping Cough
Chronic Fatigue, High Blood Pressure, Fibromyalgia, Other______________________

Women - How many children?_____Pregnant?_____Date of last Menstrual Cycle________

Nursing?_____Taking Birth Control Pills?______

Previous Surgeries and Dates? ____

List ALL Medications you are currently taking ____________________________

What kind of exercise do you do? ____________________________________

What supplements do you take?______________________________________

How much do you smoke per day?____________ Drink per week? ______________

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature______________________________ Date______________