Survey Location ______________ Date ________ Appointment Date ________ Time ______

HEALTH SURVEY

Name ______________________ Place of Employment ______________________

Address ______________________ City ________ St ________ Zip ____________

Home Phone ______________ Wk Phone ______________ Cell ______________

E-Mail ______________________ Date of Birth ____________ Age ________

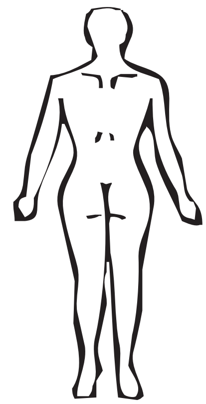
1. PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPIRIENCED IN THE LAST 2 MONTHS

❑ Headaches
❑ Stiff Neck
❑ Migraines
❑ Whiplash
❑ Upper Back Pain
❑ Middle Back Pain
❑ Lower Back Pain
❑ Sciatica
❑ Leg/Hip Pain
❑ Shoulder Pain
❑ Wrist Pain
❑ Pain w/ Activity
Numbness/Tingling
Chronic Pain
Fibromyalgia
Osteoarthritis

Which of these symptoms is the worse ______________________
How long have you had it ______________________
How often does it occur ______________________
How does it feel at its worst? Circle One: No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

How does it affect you at it's worst?
❑ No Effect
❑ Moody
❑ Irritable
❑ Interrupts Sleep
❑ Restricts Daily Activities
❑ Restricts Recreational Activities
❑ Decreases Work Productivity
❑ Other ____________

How important is it to uou to eliminate this problem?
Circle One: Not Important 1 2 3 4 5 6 7 8 9 10 Very Important



Are You Pregnant? ❑ Yes ❑ No

Please circle your areas of pain on the figure

After your initial free in-office evaluation, exam & x-rays, you may choose one addiiional free service to be done on the next visit :
Aqua Sooth Massage/Roller Table   Personal Training Consult   Pilates Consult   Cholesterol Screening

2. HAVE YOU EVER HAD ANY INJURIES OR ACCIDENTS

❑ Auto (mo/yr) ____________ ❑ Work (mo/yr) ____________ ❑ Other (mo/yr) ____________

If yes, please give details of accident ______________________________

3. WHAT TYPE OF DOCTORS ARE YOU CURRENTLY SEEING?

❑ Medical Doctor
Last Visit ____________

❑ Chiropractor
Last Visit ____________

Physical Therapist
Last Visit ____________

❑ Hospital
Last Visit ____________

4. HEALTH INSURANCE INFORMATION. THIS HELPS KEEP US INFORMED OF TYPES OF INSURANCE BEING USED

Do You have Insurance? ❑ Yes ❑ No; If yes, ❑ HMO or ❑ PPO or ❑ Other ______, Name of Insurance Co. ______________

PRIVACY PLEDGE AND AUTHORIZATIONS

We are very concerned with protecting your privacy. We understand and will respect the privacy of your health information. The information provided on this survey will NOT be disclosed to ANY OTHER facility, company or organization.
From time to time our practice would like to inform you of any special products or special services being offered by us. We may mail information to you or call you to let you know of these special offers. You have the right to deny this service by not signing below.

If you would like for us to call you, please sign and date below. This will expire seven years after the date signed.

Print Name ______________________________ Date ______________

Signature ______________________________