# Coventry Chiropractic Rehab

## Confidential Health Questionnaire

Date: _____

## Personal Information

Patient Name:_____

Home Phone #: _____

Work Phone #: _____

Cell Phone # _____

E-mail (optional): _____

Address (Street): _____

City: _____

State: _____ Zip: _____ Marital Status: _____

Date of Birth:_____

Emergency Contact: _____

Phone Number: _____

How did you hear about us? _____

Have you ever been to a Chiropractor? ☐ Yes ☐ No

If yes, when? _____

Have you ever had ultrasound therapy? ☐ Yes ☐ No

Have you ever had electric stimulation therapy? ☐ Yes ☐ No

## Insurance Information

Patient's Employer Name: _____

Work Phone #:_____

Primary Insurance Plan: _____

Policy #: _____

Group #: _____

Do you have a secondary Insurance? ☐ Yes ☐ No

Relationship to insured: ☐ Self ☐ Spouse ☐ Child

**Please fill out below ONLY if insured is different than patient:**

Insured's Name: _____

Home Phone #: _____

Birth Date: _____

Insured's Employer: _____

Work Phone #: _____

## Current Health Condition

Primary Complaint: _____

What caused this condition? (*circle*) Overexertion Strenuous Position Auto Accident Work Accident Fall

Trip Repetitive Action Other: _____

Date you were first aware of pain? _____

How would you describe the pain? (*circle*) Dull Ache Sharp Stabbing Throbbing Other: _____

How would you describe the severity of the pain? (*circle*) Mild Slight Moderate Severe Other: _____

How long does the pain/symptom last? (*circle*) Intermittent Occasional Frequent Constant Other: _____

What relieves the problem? (*circle*) Rest Exercise Sitting Standing Lying Other: _____

Have you ever had the same or similar problem before? ☐ Yes ☐ No

If yes, explain: _____

Have you ever had medical treatment for this condition before? ☐ Yes ☐ No

If yes, when/what? _____

over →

## Past Health History

General Health: ☐ Excellent ☐Good ☐Fair ☐ Poor (explain) _____

Are you: ☐ Right-handed ☐ Left-handed

In what position do you generally sleep? ☐ On my back ☐ On my side ☐ On my stomach

Do you have any trouble sleeping? ☐ Yes ☐ No If yes, explain: _____

Approximately how many hours do you sleep per night? _____ hours

Alcohol consumption: ☐Yes ☐ No Tobacco: ☐Yes ☐ No Drugs: ☐ Yes ☐ No

Any known allergies? ☐ Yes ☐ No If yes, explain: _____

## Injuries/Surgeries

| | DATE | EXPLANATION |
|---|---|---|
| Hospitalization(s) | _____ | _____ |
| Major accidents or falls? | _____ | _____ |
| Surgeries | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Dislocations | _____ | _____ |

Do you have any of the following? ☐ Pacemaker ☐ Surgical Staples ☐ Metal Plate ☐ Other:

## Medications/Supplements

Do you take any nutritional supplements? ☐ Yes ☐ No

If yes, what: _____

_____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, what medication and for *what* health condition?

_____

_____

_____

## Diet/Exercise

Do you exercise? ☐ Yes ☐ No If yes, times/wk: _____

Type: _____

Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

(Explain):

Any other health problems? ☐ Yes ☐ No

If yes, explain: _____

_____