

Welcome To Our Office

GRAFTON CHIROPRACTIC CENTER

TODAY'S DATE _____

About You

Thank you for choosing our office.

In order to serve you properly we will need the following information (Please print.) All information will be kept strictly confidential.

Patient's name		Birthdate	Age	Home Phone
Residence address	City	State	Zip	Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
Social security number	E-mail		Cell Phone	
Name of employer	Address	Occupation	Business phone	
If child, parent's name or guardian's name		Primary Physician		
Ladies, in the event that you may need an X-ray, are you pregnant?				

Insurance Info

Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, how do you intend to pay? <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit card	Ins. Co. name
Insured name	Patient's Relationship to Insured	
Complete the following if you are NOT the insured	Insured's Birthdate	Insured's Social Security Number
Insured's Employer	Work Phone Number of Insured	
Is there secondary Ins.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Secondary Insurance Company Name	Insured name

Accident Info

Is this visit the result of an accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Auto Collision	<input type="checkbox"/> Personal Injury
Is this visit the result of a work injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		

Whom may we thank for referring you?

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. I authorize payment of medical benefits to Meske-Ziegler Chiropractic.

Patient, Parent, or Guardian Signature _____ Date _____

Please turn over and complete backside

PATIENT HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

1. Please Describe Your Complaint: _____

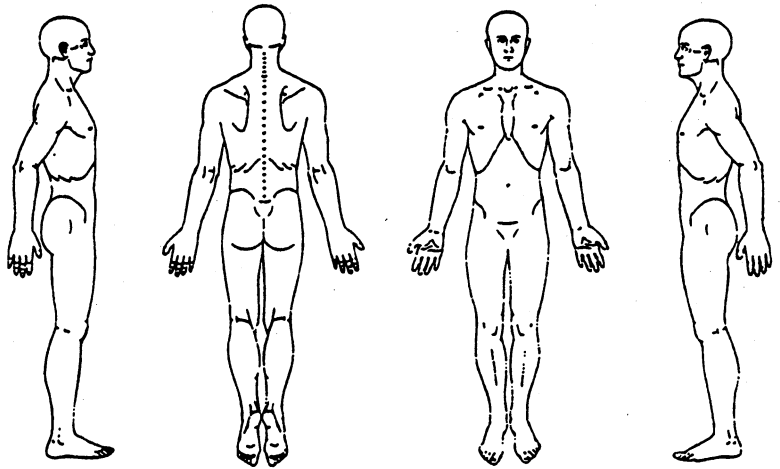
a. Description:

- Sharp Pain
- Dull Pain
- Ache
- Weak
- Throbbing
- Numb
- Shooting
- Burning
- Tingling

b. Frequency:

- Constant (76-100%)
- Frequent (51-75%)
- Occasional (26-50%)
- Intermittent (25% or less)

MARK ON THE
PICTURE WHERE YOU
HAVE PAIN OR OTHER
SYMPTOMS.



c. Indicate intensity of your pain at its lowest and highest level: No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

2. When did your problem begin: (specific date if possible) _____
Briefly describe how your problem began: _____

3. Have you been treated for this episode? Yes No
If yes, by whom? Chiropractor MD Osteopath Physical Therapist Occupational Therapist Other _____
Are you currently being seen? Yes No

4. In the past have you been treated for the same or a similar problem? Yes No
If yes, who did you see for that episode? Chiropractor MD Osteopath Physical Therapist
 Occupational Therapist Other _____

5. How would you rate your stress level? Little or no stress Minimal Stress Moderate Stress Greatly Stressed

6. How are your complaints affecting your ability to be active?
 No effect Need assistance often.
 Need limited assistance with common everyday tasks Have a significant inability to function without assistance.
 Some physical restrictions (able to perform light duty work and household tasks) Am totally disabled (impaired). Cannot care for self.

7. What is your current work status?
 Full time, no restrictions Part time, with restrictions Unemployed Other: _____
 Full time, with restrictions. Off work due to restrictions Retired
 Part time, no restrictions. Full time homemaker. Full time student.