Cambridge Clinic of Chiropractic
New Patient Questionnaire

Patient Information

Patient I.D. _____

PLEASE PRINT USING BLACK INK

Name_____ **Date**_____ **SS#**_____

Address_____**City**_____ **State**_____ **Zip**_____

❑**Male** ❑**Female** ❑**Married** ❑**Single** ❑**Widowed** ❑**Divorced** ❑**Separated**

Birthdate_____ **Home Phone**_____ **Cell**_____

Work Phone_____ **E-mail Address**_____

Preferred method of contact = ❑**Mail** ❑**Cell phone** ❑**Home phone** ❑**E mail**

Occupation_____ **#years**_____

Spouse or Parent's Name_____ **Birthdate**_____ **Phone** _____

Emergency Contact_____ **Phone** _____ **Relation**_____

Whom may we thank for referring you to us? _____

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 free - 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 _____

_____

Any known allergies?_____

Any known drug allergies?_____

What kind of exercise do you do? _____

Smoking: ❑**Current smoker** ❑**Former smoker** ❑**Never smoked** **Drinks per week?**___

Do you have any high stress activities?_____

***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**_____

PATIENT NAME _____

DATE _____ Doctor: DiPiazza, Matthew

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

Signature of Patient/Legal Guardian _____

Date _____