**Billing Questionnaire**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Phone #: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Other/Partner Name:

Emergency Contact Name (if not the same as above):

Emergency Contact Phone #:

Employer Name:

Insurance Info: **BRING IN CARD TO PHOTOCOPY**

Guarantor’s Name:

Guarantor’s DOB:

Motor Vehicle Accident

Policy #:

Claims #:

Company, Agent Name, Phone number and email:

**Medical History Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_Gender: M F

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Practitioners (massage, chiropractor, acupuncturist, physicians):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you: Right Handed Left Handed Ambidextrous

Why are you seeing the doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this problem? (Date of Injury)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a Workplace or Motor Vehicle Injury? Y N

Describe how the injury/accident occurred:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are experiencing pain(s), where is it located?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate the intensity of your pain/discomfort. (0=no pain, 10= severe pain). Indicate a range if your pain varies:

0 1 2 3 4 5 6 7 8 9 10

Please circle a description(s) of your pain:

off and on constant dull sharp throbbing tight burning tingling cramping aching

Is your pain worse at a particular time of the day?

Morning Daytime Night

In the affected area, do you have (If yes, please describe):

Stiffness Y N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Numbness Y N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Swelling Y N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weakness Y N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instability Y N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apprehension Y N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Y N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities or movement makes your pain/discomfort worse?

Please describe any other previous injury to the area in question.

Have you tried any of the modalities below for this injury?

Medication Y N Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Therapy Y N How long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injections Y N Location of Injection:\_\_\_\_\_\_\_\_\_\_\_

Brace Y N

Other (chiropractor, massage, acupuncture) Describe:

**Past Medical History & Family History**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | SELF | Mother | Father | Siblings | Grand-  parents | Children |
| Alcoholism |  |  |  |  |  |  |
| Alzheimer |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |
| Asthma/Lung  Issues |  |  |  |  |  |  |
| Bleeding Disorder |  |  |  |  |  |  |
| Cancer(s) |  |  |  |  |  |  |
| Depression/  Anxiety |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| Drug Abuse |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |
| Glaucoma/Eye  problems |  |  |  |  |  |  |
| Heart Disease, attack,palpitations) |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |
| High Blood  Pressure |  |  |  |  |  |  |
| Intestinal Issues:  IBS, stomach |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |
| Liver Disease:  Hepatitis |  |  |  |  |  |  |
| Migraines |  |  |  |  |  |  |
| Thyroid Issues |  |  |  |  |  |  |
| OTHER: |  |  |  |  |  |  |

Past SURGERY, HOSPITALIZATIONS and/or ACCIDENTS

Date SURGERIES/Medical Issue

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS & SUPPLEMENTS:

Name Dose Frequency Name Dose Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_

ALLERGIES/SENSITIVITIES (please list):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL:

Do you drink Alcohol? Y N How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Tobacco? Y N How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you did in the past, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you follow a special Diet? Y N What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? Y N How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other Hobbies? Y N

What are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How tall are you? \_\_\_\_\_\_\_\_\_\_\_\_\_ How much do you weigh? \_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following that haven’t been addressed elsewhere?

(circle all that apply)

Fever Headaches Head Injury

Double vision Blurry vision Issues w/ bright light

Hearing loss Ringing of ears Nose Bleeding

Nasal congestion Dental issues TMJ

Chest Pain Palpitation Chronic Cough

Wheezing Shortness of Breath Pain w/ deep breath

Nausea Vomiting Belly pain

Constipation Loose Stools Heartburn

Loss of appetite Blood in Stool Rash

Itching Pain w/ urination Impotence

Frequent urination Irregular Menses Increased thirst

Incontinence Weight gain/loss Trouble sleeping

Low desire to have sex Brain Fog Low Energy

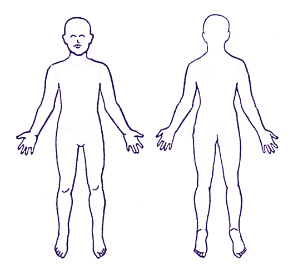
Trouble with orgasm Hair Loss Brittle nails

Pain with sex Temperature Intolerances Hot Flashes

Vaginal Dryness Heavy Period/Cramps Bleeding Gums

Suicidal thoughts Panic /Anxiety Depression

Easy bruising Leg or Feet Swelling Chronic Infection



PLEASE INDICATE WHERE YOU ARE EXPERIENCING:

**PAIN** with an X

**DISCOMFORT** with ////

**RADIATION** of the pain or discomfort with #

**SELECT THE ONE WORD IN EACH CATEGORY (1-10) THAT BEST DESCRIBES YOU:**

**Select only 1 word(s) in each of the 10 rows**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **\_\_\_\_ DETERMINED** | **\_\_\_\_ CONVINCING** | **\_\_\_\_ PREDICTABLE** | **\_\_\_ CAUTIOUS** |
| 1. **\_\_\_\_ STRONG WILLED** | \_\_\_\_ PERSUASIVE | \_\_\_\_ EASY-GOING | \_\_\_ ORDERLY |
| 1. **\_\_\_\_ DIRECT** | \_\_\_\_ EXPRESSIVE | \_\_\_\_ KIND | \_\_\_\_ ANALYTICAL |
| 1. **\_\_\_\_ BOLD** | \_\_\_\_ SOCIABLE | \_\_\_\_ COOPERATIVE | \_\_\_\_ PRECISE |
| 1. **\_\_\_\_ OUTSPOKEN** | \_\_\_\_ ANIMATED | \_\_\_\_ PATIENT | \_\_\_\_ LOGICAL |
| 1. **\_\_\_\_ DECISIVE** | \_\_\_\_ TALKATIVE | \_\_\_\_ LOYAL | \_\_\_\_ CONTROLLED |
| 1. **\_\_\_\_ DARING** | \_\_\_\_ OUT-GOING | \_\_\_\_ AGREEABLE | \_\_\_\_ CAREFUL |
| 1. **\_\_\_\_ RESTLESS** | \_\_\_\_ ENTHUSIASTIC | \_\_\_\_ CONSIDERATE | \_\_\_\_ THOROUGH |
| 1. **\_\_\_\_ COMPETITIVE** | \_\_\_\_ INSPIRING | \_\_\_\_ CONSISTENT | \_\_\_\_ DETAILED |
| 1. **\_\_\_\_ AGGRESSIVE** | \_\_\_\_ PLAYFUL | \_\_\_\_ SATISFIED | \_\_\_\_ ACCURATE |