Patient Health Questionnaire

1130 Raritan Road
Cranford, NJ 07016
908-653-1140

Name:_____ Date:_____
Address:_____ ____City:_____State:____Zip:_____
Home Ph:_____Work Ph:_____Cell Ph:_____
Best Number to contact you: Home Work Cell Email Address:_____
Birth date:_____ Age:____ Sex: M F Circle One: Single Married Partnered
Occupation & Employer:_____# of hours worked per week:_____
Significant Others's Name:_____ Significant Other's Occupation:_____
Name and Ages of Kids:_____
Who can we thank for referring you:_____
Main reason for consulting our office today:
_____

Insurance (Please give policy holder information)
Name:_____ Date of Birth:_____ Relationship to insured:_____
Address (If different from above):_____
Ins. Co. Name:_____ ID #:_____ **PLEASE PRESENT COPY OF CARD**

Any information about your Nerve System and Spine we should know:
_____

Have you been adjusted by a chiropractor before? ____Yes ____No
Office:_____ Date of last Adjustment:_____
Duration of care: _____ weeks/months/yrs

Lifestyle

- Do you use tobacco products? ____pack/week
- Check if yes: Coffee____ Alcohol____ Water____ Soda____
- Sleep/Rest Habits: Hours a night:_____ Do you wake up refreshed? Y N
- Exercise Habits: (please describe what you do and how often)

_____

- What type of work do you do?_____Satisfied/Enjoy your work? Y N
- Do you use prescription, over the counter and/or recreational drugs/medications? Y N (If yes, please list)

_____

- What are your current play and relaxation activities?

Turn Over

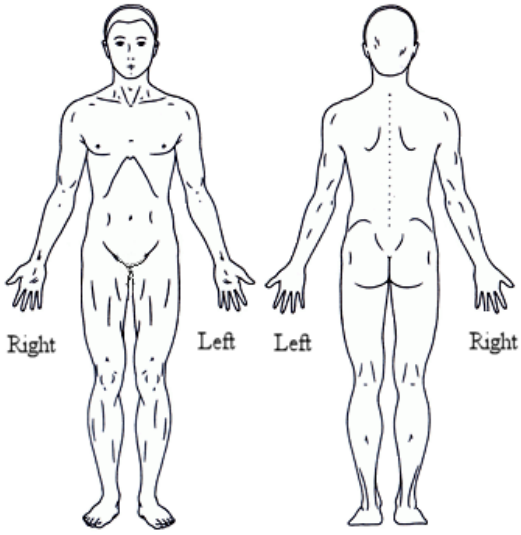
Check any of the symptoms or conditions below that you experience?

___Headaches	___Carpal Tunnel	___Asthma	___Digestive Problems
___Neck Pain	___Problem Sleeping	___Vertigo	___Pain Between Shoulder Blades
___Mid-Back Pain	___Ringing in Ears	___ Cancer	___Shortness of Breath
___Low-Back Pain	___Loss of Balance	___ Allergies	___Tension across Top of Shoulders
___Sciatic Pain	___High Blood Pressure	___ Dizziness	___ Numbness in Arms/Legs
___Leg or Hip Pain	___Weight Trouble	___Depression	___ Menstrual Pain
___Shoulder/Arm Pain	___Low Energy/Fatigued	___Other_____	

Which one of the above symptoms is worst?_____
How long have you had it?_____

Using the symbols below, mark on the pictures where you feel pain:

Numbness	NNN
Dull Ache	AAA
Burning	BBB
Sharp/Stabbing	SSS
Pins, Needles	PPP
Other _____	XXX



Terms of Service

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.
HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.

Through your exam and with each visit we will identify where the levels where your spine is subluxated. Those will be the areas where you will be adjusted in order to increase your body's ability to function and heal, increasing your overall health.

I,(Name)_____ (Signature)_____ undertake any care with the understanding of and agreement with, the above explanation. _____(Date)

Consent to evaluate and adjust a minor and/or child: I, _____ (Print name) being the parent or legal guardian of _____(Print name) give permission for my child to receive any care. (Signature)_____