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Patient Assessment Questionnaire

Name:____ Date: ______________
Address: ___________________________ City/State: _________________ Zip: _______________
Birth date: ______________________ Age: _________

Marital Status (circle one): Single Married Widowed Divorced How Long: ___________

Phone 1: _______________Phone 2: _____________ E-mail: ____________________________

Is it okay to leave a voice message? (Circle one or all) Home Cell Work None

May we send you e-mail newsletters? Yes □ No □

How should we send you appointment reminders? □ Text (please also list your cell phone provider so our system can send texts to your phone: ______________________□ E-mail_________________

Occupation: __________________________ Employer: ______________________________

How did you hear about our practice (check one):

□ Referral from another patient (if so who may we thank for your referral): ____________

□ Website

□ Social Media

□ Other: ________________________

Please list your health concerns in order of importance that you wish to address:

Concern	Date of Onset	What makes it better?	What makes it worse?	Severity (1 -10)

Have you had laboratory testing completed in the past 12 months? □ Yes □ No
Please bring a paper copy of your testing results to your appointment if you are able.

Other doctors seen for your complaint (s):

□ Chiropractic Care (D.C.) Were you satisfied? Yes □ No □ Name: ____________________________

□ Medical Care (M.D.) Were you satisfied? Yes □ No □ Name: ____________________________

□ Other Care Were you satisfied? Yes □ No □ Name: ____________________________

Office Policies: *I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, that Parrish Chiropractic and Functional Health will prepare the necessary reports and claims to assist me in reimbursement from the insurance company and that any amount authorized to be paid directly to Parrish Chiropractic and Functional Health will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that no cures are promised and any risks regarding care will be explained to me. I now authorize Parrish Chiropractic and Functional Health to proceed with necessary care and treatment.*

Patient (Guardian) Signature: ____ Date: ___________________

List all prescriptions, over-the-counter medications and herbal, homeopathic, hormonal, and nutritional (vitamins/minerals) supplements, you are **currently taking: (**Use back of page if more space is needed.)

Medication/Supplement	Dose	Condition taken for	Time of day taken

Surgical History

Please list all medical procedures and surgeries:

Surgery/Procedure	**Date**	**Reason for procedure**

Any Hospitalizations in the last 5 years, if so what was the reason for the visit?

____

Past Medical History

Which of the following conditions have you been diagnosed present or past?

√ Mark the following conditions

□ Abscesses	□ Tonsillitis	□ Goiter	□ Lactose Intolerant	□ Malaria
□ Diabetes	□ Peritonitis	□ Measles	□ Epilepsy/Seizures	□ Skin Disease
□ Heart Disease	□ Pleurisy	□ Kidney Disease	□ Warts	□ Stroke
□ Mumps	□ Chicken Pox	□ Worms/Parasites	□ Prostatitis	□ Gallstones
□ Asthma	□ Eating Disorder	□ Tuberculosis	□ Leukemia	□ Hepatitis
□ Pelvic Inflammatory	□ Rheumatic Fever	□ Mononucleosis	□ Typhoid Fever	□ Pneumonia
□ Cold Sores	□ HIV	□ Appendicitis	□ Venereal Disease	□ Psychiatric Disorder

□ High Blood Pressure □ Cancer (type): ____

List any other conditions the doctor should be aware of:

____

____

Have you ever taken any of the following medications?:

Birth Control □	Antibiotic □	Antidepressant □	Hormones □	Antifungal □
Weight Loss □	Blood Pressure □	Cholesterol Lowering □	Anticoagulants □	

Please list all allergies and sensitivities (food, environmental, and seasonal):

____

**** Female Patients **** Are you pregnant at this time? □ No □ Yes Due Date: ___________________

Hysterectomy: □ Full □ Partial Year: _______ Menopausal: □ Yes □ No Perimenopausal: □ Yes □ No

System Review

√ Mark the following conditions you are **currently** experiencing (past 30 days).

General

□ allergies	□ chills	□ convulsions	□ depression	□ bruise easily
□ loss of weight	□ fatigue	□ fever	□ hives	□ loss of sleep
□ weight gain	□ itching	□ night sweats	□ wheezing	□ nervousness

Gastrointestinal

□ constipation	□ diarrhea	□ vomiting blood	□ hemorrhoids	□ jaundice
□ liver problems	□ nausea	□ stomach pain	□ poor appetite	□ poor digestion
□ rectal bleeding	□ vomiting	□ gall bladder problems		

Eye/Ear/Nose/Throat

□ asthma	□ double vision	□ deafness	□ earache	□ ear discharge
□ ear noises	□ enlarged thyroid	□ frequent colds	□ hay fever	□ loss of smell
□ nasal obstruction	□ nose bleeds	□ pain in eyes	□ poor vision	□ sinusitis
□ tonsillitis	□ difficulty swallowing			

Respiratory

□ chest pain □ chronic cough □ spitting blood □ spitting phlegm □ difficulty breathing

Muscles/Joints/Bones

□ backache □ foot problems □ shoulder pain □ hip pain □ painful tailbone
□ deformity □ swollen joints □ knee pain □ limping □ weakness

Cardiovascular

□ ankle swelling □ chest pain □ coughing blood □ weakness □ high blood pressure
□ poor circulation □ rapid heart □ slow heart □ shortness of breath □ low blood pressure

Genitourinary

□ burning on urination □ painful urination □ recurrent bladder infection
□ increased urination at night □ blood in urine □ difficulty starting
□ increased urination at day □ kidney stones

Family History

√ Mark the following conditions as they pertain to your immediate family.

	Mother	Father	Brother	Sister	Children
Diabetes					
Hypertension					
Heart Problems					
Kidney Problems					
Cancer					
Obesity					
Scoliosis					
Back Problems					
Osteoporosis					
Headaches					
Birth Defects					
Thyroid					
Smoker					
Anemia					

Lifestyle

Do you diet, if so how often and what diet(s) have you tried? ____

Do you exercise, if so how often?____

Changed jobs: Within Last 2 Months_____ Last 6 Months_____ Last 12 Months_____

Work over 60 hours/week: Always _____ Usually _____ Occasionally _____ Never_____

	Do Not Consume/Use	Daily	Weekly	2-3 Times/ Month
Alcohol				
Tobacco				
Vaping				
Dine Out				
Eat Prepared Meals				
Exercise				
Artificial Sweeteners				
Candy or Other Sweets				
Carbonated Beverages				
Coffee				
Corn Products				
Fried Foods				
Gluten/Wheat Products				
Luncheon Meats/Hot Dogs				
Margarine				
Milk Products/Dairy				
Non-Herbal Tea				
Peanut Products				
Refined Sugar				
Refined Flour/Baked Goods				
Soy Products				
Water, Distilled				
Water, Tap				
Water, Well				