

INSURANCE QUESTIONNAIRE

-PLEASE ANSWER ALL QUESTIONS COMPLETELY-

PATIENT INFORMATION:	DATE: _____
Name: _____	SS#: _____
Sex: Male / Female	E-mail address: _____
Marital Status: <u> S </u> <u> M </u> <u> D </u> <u> W </u>	Are you a minor?: Y / N
Birth Date: ____ / ____ / ____	Age: _____
Address: _____	
Home Phone: () _____	Cell Phone: () _____

EMPLOYMENT INFORMATION:	
Employer / Business Name: _____	
Phone #: () _____	EXT: _____
Address: _____	
Job Title: _____	

INSURANCE INFORMATION:
Insurance Company: _____
Policy Number: _____
Name of policyholder: _____
Relationship to Patient: _____

I understand and agree that health insurance policies are an agreement between my insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to my carrier and I may be personally responsible for payment if services are not covered.	
Patient Signature: _____	Date: _____

How were you referred to our office? _____

PAIN DRAWING

Name: _____

Today's Date: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols(s) listed below.

Ache >>>>
>>>>

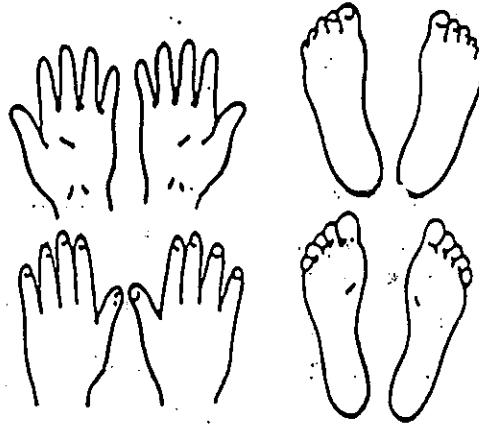
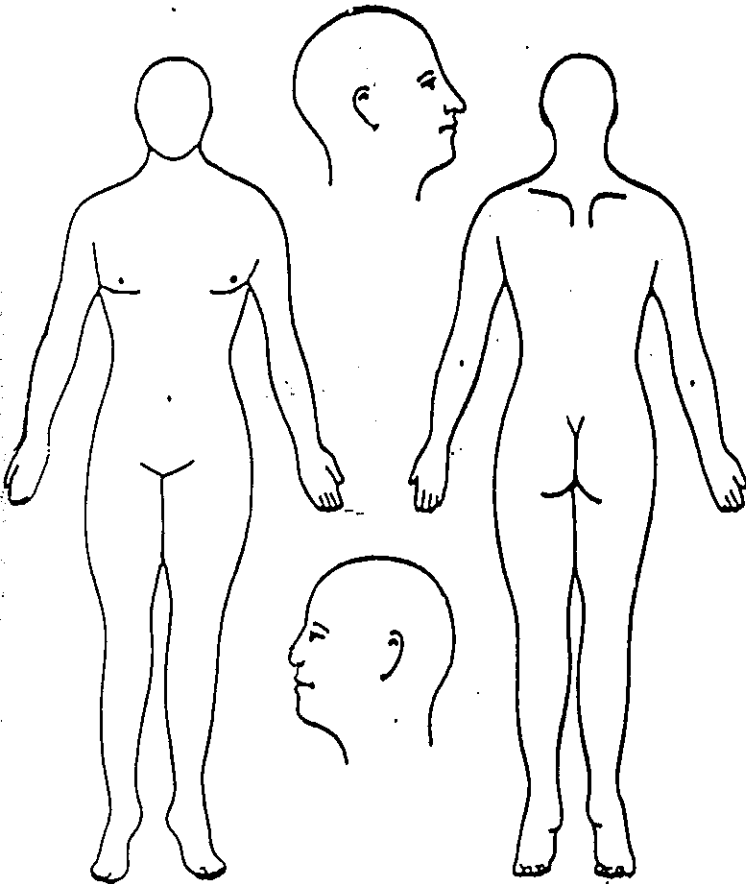
Numbness ■■■■
■■■■

Pins and Needles ○○○○
○○○○

Burning x x x x
x x x x

Stabbing // // //
// // //

Throbbing - - - -
- - - -



SEVERITY OF PAIN

List region of pain and circle severity number. (1 = least, 10 = greatest)

ex. Neck
1 2 3 4 5 6 7 8 9 10

1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

5. _____
1 2 3 4 5 6 7 8 9 10

HEALTH QUESTIONNAIRE

PLEASE CHECK ALL THAT APPLY:

MUSCULO SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Rupture
- Broken bones

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
- Yes No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO VASCULAR RESPIRATORY SYSTEM

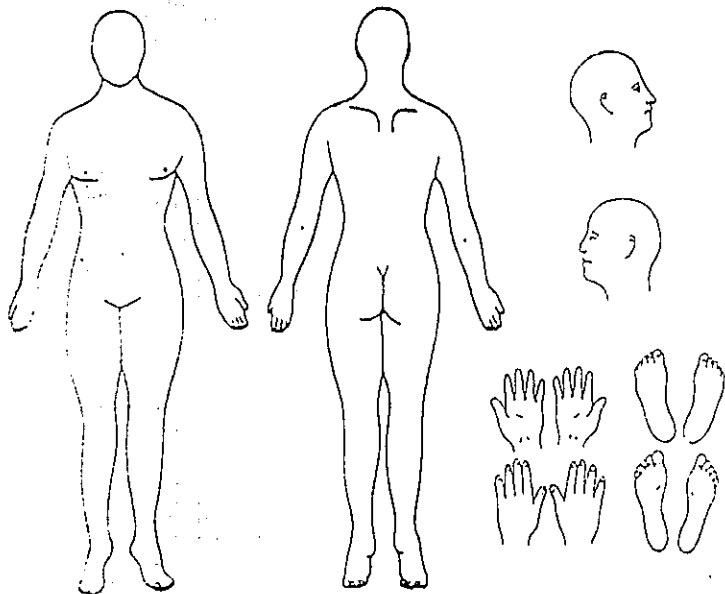
- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYES, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression



Patient's Signature

*****DO NOT WRITE BELOW THIS LINE*****

Patient Accepted? Yes No Doctor's Signature _____

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sschiropractic@optonline.net

I _____ fully understand that I am directly and fully responsible for any and all payment of services rendered to me by Michael J. Campo, DC of South Shore Chiropractic, PC.

Print Name _____

Sign Name _____

Date _____

Witness _____