

Zimmermann Chiropractic & Wellness Center, LLC

New Patient Questionnaire

Patient Information

Please Print

Name _____ Birthdate _____ SS# (Last 4 digits) _____

Address _____ City _____ State _____ Zip _____

Male Female Married Single Widowed Divorced Separated

Home Phone _____ Cell# _____ Cell Carrier _____

Work Phone _____ E-mail Address _____

Employer _____ Occupation _____ #years _____

Spouse or Parent's Name _____ Spouse's Birthdate _____

Emergency Contact _____ Phone _____ Relation _____

Name of local primary Physician _____ May we contact them? _____

Main Complaint:

How often is it present? 95% _____ 50% _____ 25% _____ of the time

When did it start? _____ Getting Worse? _____ Getting Better? _____

What activity bothers it the most? _____

What activity makes it better? _____

Rate the pain - (0 is pain free - 10 worse possible pain) 1 2 3 4 5 6 7 8 9

Have you had any previous treatment for this complaint? No , Yes , please list types of treatment(s) _____

Secondary Complaint(s) _____

Height: _____ ft _____ inches, Weight: _____ lbs.

Health/Family History - Please circle all that apply to you and check for all that apply to your family

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				

Allergies: _____ Other illness or injuries: _____

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 _____

What kind of exercise do you do? _____

What supplements do you take? _____

How much do you smoke per day? _____ Drink per week? _____

*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 _____