



Community Chiropractic
Consultation Questionnaire

PATIENT NAME _____

DATE _____

Dr. Vicki Danis

Dr. Emileah Van Matre

Please answer questions below in detail. Please circle where appropriate.

1. What is your major symptom? _____

2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes No Same Better Gradually Worse
If yes, when and how? _____
4. How frequent is the condition? Constant Daily Intermittent Night Only
How long does it last? All Day Few Hours Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom?
Yes No If yes, describe: _____
Are there other current health problems? Yes No If yes, describe _____

6. Please rate your pain on a scale of 1-10, with 10 being the worst: _____
7. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing
Other _____
8. Is there anything you can do to relieve the problem? Yes No If yes, describe _____
_____. If no, what have you tried to do that has not helped? _____

9. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting
Other _____
10. List any major accidents you have had other than those that might be mentioned above:

11. Other Remarks: _____



Community Chiropractic
7651 E US Hwy 36
Avon, IN 46123
(317) 272-7988

Chiropractic Case History/Patient Information

Date: _____

Doctor: Vicki Danis, DC

Emileah Van Matre, DC

Name: _____ Social Security # _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell Phone: _____ Cell Carrier: _____

Age: _____ Birth Date: _____ Marital Status: M S W D Preferred Contact Number (circle): Home Cell

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Who can we contact in case of an emergency? _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

OB/GYN (if applicable): _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
 Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone (other than the parties mentioned above) that you do want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____



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Emileah Van Matre, DC

HISTORY OF PRESENT AND PAST ILLNESS:

Have you ever had the same or a similar condition for which you are presenting? Yes No

If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? _____

List dates of any **major** illnesses, injuries, broken bones, auto accidents or surgeries. Women, please include information about childbirth: _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications and/or supplements are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Do you have any Congenital Condition? Yes No If YES, Describe _____

Do you have (or had within the last 3 months) any of the following symptoms/conditions? Please place a check next to the condition.

- | | |
|---------------------------------|--------------------------------|
| Headaches _____ Frequency _____ | Loss of Balance _____ |
| Neck Pain _____ | Fainting _____ |
| Stiff Neck _____ | Unusual Bowel Patterns _____ |
| Nervousness _____ | Feet /Hands Cold _____ |
| Chest Pains/Tightness _____ | Dizziness _____ |
| Shoulder/Neck/Arm Pain _____ | Numbness in Fingers/Toes _____ |
| Diabetes _____ | High/Low Blood Pressure _____ |
| Indigestion Problems _____ | Joint Pain/Swelling _____ |
| Weakness in Extremities _____ | Menstrual Difficulties _____ |
| Breathing Problems _____ | Weight Loss/Gain _____ |
| Fatigue _____ | Depression _____ |
| Lights Bother Eyes _____ | Loss of Memory _____ |
| Ears Ring _____ | Broken Bones/Fractures _____ |
| Circulation Problems _____ | Rheumatoid Arthritis _____ |
| Seizures/Epilepsy _____ | Osteoarthritis _____ |
| Osteoporosis _____ | Pacemaker _____ |
| Heart Disease _____ | Stroke _____ |
| Cancer _____ | Gallbladder issues _____ |



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SOCIAL HISTORY

Please indicate beside each activity if you engage in it with a **YES**

_____ Exercise ; If so, How Often? _____ Family Pressures
 _____ Financial Pressures _____ High Stress Job _____ Other Mental Stresses
 _____ Alcohol Use (How often? _____) _____ Previous/Current (Circle one) Drug Use
 _____ Tobacco Use (How much/often? _____) _____ Other (specify) _____
 _____ Caffeine (How much daily? _____)

Have you received chiropractic care previously? _____

If so, where? _____ Name of Doctor: _____

Describe your experience: _____

FAMILY HISTORY: Please check the following box if it applies, and describe as necessary.

Condition	Father	Mother	Spouse	Brother/Sister	Children
Arthritis					
Disc Problem					
Pinched Nerve					
Headaches					
Migraine					
Scoliosis					
Insomnia					
Asthma					
Emphysema					
Sinus Trouble					
Stomach Trouble					
Liver Trouble					
Kidney Trouble					
Epilepsy					
Heart Trouble					
High Blood Pressure					
Stroke					
Diabetes					
Cancer (Please List)					
Other:					

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient _____

Date: _____