



NEW CHIROPRACTIC PATIENT QUESTIONNAIRE

Patient# _____ Date _____

NAME _____ DATE OF BIRTH _____
ADDRESS _____ HOME PHONE _____
CITY/ST _____ ZIP _____ CELL PHONE _____
OCCUPATION _____ WORK PHONE _____
E-MAIL ADDRESS _____
MARRIED___ SINGLE___ WIDOW(ER)___ DIVORCED___ NUMBER OF CHILDREN_____

SPOUSE _____ EMPLOYMENT _____ WORK # _____

Whom may we thank for referring you to us? _____

Personal Habits

Are you currently using any: ___ Medications ___ Drugs ___ Tobacco ___ Alcohol
___ Coffee ___ Vitamins/Minerals/Herbs ___ Exercise

List all medications you are currently taking _____

Present Health Condition

Height _____ Weight _____ Have you experienced any significant weight change in the past three months? ___ Yes ___ No.
If yes, please describe change _____

Please list your symptoms below in order of importance and give date symptoms began.

- 1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Is this condition due to an auto accident? ___ Yes ___ No. If yes, list date of accident _____. Who was at fault? _____

Is this condition a direct result from an injury which occurred at work? ___ Yes ___ No. If yes, date and time of injury _____
Did you report this injury to your employer? ___ Yes ___ No.

Do you have health insurance? ___ Yes ___ No. If Medicare, please present your insurance card at the front desk.

In case of an emergency who should be contact? Name _____ Daytime phone # _____
Relationship? _____

*I understand and agree that all services are charged directly to me and that I am personally responsible for payment. I also
understand that if I suspend/terminate my care, all fees for services will be immediately due. Payment is expected at time of visit.

Patient/Guardian Signature: _____ Date _____

If under 18, parental consent required: I (please print) _____ give Back To Health Center
Permission to treat my son/daughter with chiropractic care. Parent/Guardian signature: _____

Please complete Health History on back of this page

Health History

Have you ever had the same or similar symptoms? ___ Yes ___ No. If yes, when? _____

Have you had treatment by another doctor for these symptoms? ___ Yes ___ No.

If yes, name of doctor _____.

Is there any family history of this type of pain? ___ Yes ___ No.

Have you had any previous Chiropractic care? ___ Yes ___ No.

Have you ever been hospitalized? ___ Yes ___ No. If yes, when and why? _____.

Have you ever broken any bones? ___ Yes ___ No. If yes, when and what? _____.

Have you noticed any recent changes in bowel or bladder habits? ___ Yes ___ No. If yes, please describe _____.

Please check below if you or a member of your family has ever been diagnosed with or suffered from:

You Family Relationship (Father, Mother, Sister ...)

- | | | | |
|-------|-------|-------|--|
| _____ | _____ | _____ | 1. Cancer |
| _____ | _____ | _____ | 2. Diabetes |
| _____ | _____ | _____ | 3. Thyroid Disease |
| _____ | _____ | _____ | 4. Hypertension (High Blood Pressure) |
| _____ | _____ | _____ | 5. Hypercholesterolemia (High Cholesterol) |
| _____ | _____ | _____ | 6. Atherosclerosis (Heart Disease) |
| _____ | _____ | _____ | 7. Kidney Disease |
| _____ | _____ | _____ | 8. Osteoporosis |
| _____ | _____ | _____ | 9. Neuromuscular Disease (i.e. Parkinson's, Multiple Sclerosis) |
| _____ | _____ | _____ | 10. Rheumatoid arthritis |
| _____ | _____ | _____ | 11. Allergies/Asthma |
| _____ | _____ | _____ | 12. Scoliosis |
| _____ | _____ | _____ | 13. Low back pain/or surgery |
| _____ | _____ | _____ | 14. Headache/Migraine |
| _____ | _____ | _____ | 15. Gastrointestinal Problem (Gallbladder, Ulcers, Diverticulitis) |
| _____ | _____ | _____ | 16. Liver Disease (Hepatitis, Cirrhosis) |
| _____ | _____ | _____ | 17. Other _____ |

Please notify the Doctor if you suffer from any medical condition not listed on this form.

Female Health History

Date of last menstrual cycle _____. Was it ___ regular or ___ irregular?

Is there any possibility that you are pregnant? ___ Yes ___ No ___ Maybe

Are you using some form of birth control pill? ___ Yes ___ No. If yes, what kind _____.

Do you have an annual gynecological exam? ___ Yes ___ No.

If over 40, do you have a regular mammogram? ___ Yes ___ No

Male Health History

Do you have a regular prostate exam? ___ Yes ___ No

Have you had a recent Prostate Specific Antigen test? ___ Yes ___ No

Primary Care Provider

Do you have a primary care physician? ___ Yes ___ No.

Doctor's name: _____

Phone #: _____

Office Address: _____.

FAX: _____

If you would like us to send any records from your visits at Back To Health Center to your primary physician, please ask for a release of records form at the front desk, and be sure to provide us with the doctor's name and fax number.

Van D. Merkle, DC, CCN, DACBN, DACBI

Natalie Yahle, DC

Andrew Dyer, DC, DABCA

5785 Far Hills Ave, Dayton, Ohio 45429

Email: mail@bk2health.com

Phone: (937) 433-3241

Fax (937) 439-0088