Franklin Park Chiropractic Center

3545 N Rose Street
Franklin Park, Illinois 60131

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

PERSONAL INFORMATION
Your Name: ____ Date:________________
Address: ______________________________ City: ______________ State: ___ Zip: __________
Home Ph: (____)_____-_______ Cell Ph: (____)_____-________ Work Ph: (____)_____-________
Your Occupation: _________________________ Employed by:______________________________
Work Address: __________________________ City: ______________ State: ___ Zip: __________
Age: ______ Date of Birth: ____/____/________ *(mm/dd/yyyy)* SS#: _____-____-_______
Marital Status: M S D W Name of Spouse/Guardian(*if applicable*):_______________________
Spouse/Guardian's Employer:___________________________________ Ph: (____)_____-_________

NEWSLETTER
In order to keep you up to date on the latest health related news and FPCC event we would like to send you a monthly newsletter. Please select one of the following:
Send the newsletter to my e-mail account E-mail: ________________________________

IS SOMEONE ELSE RESPONSIBLE?
Is your visit due to a personal injury accident (i.e. work or car accident)? Yes No
If "yes" please present your accident documents to our staff at this time!

EMERGENCY CONTACT INFORMATION
(if this is the same as your spouse or legal guardian write "spouse" or "guardian")
Name of person to contact in case of emergency:____
Relationship to you: ______________ Home Ph: (____)_____-______ Cell Ph: (____)_____-______

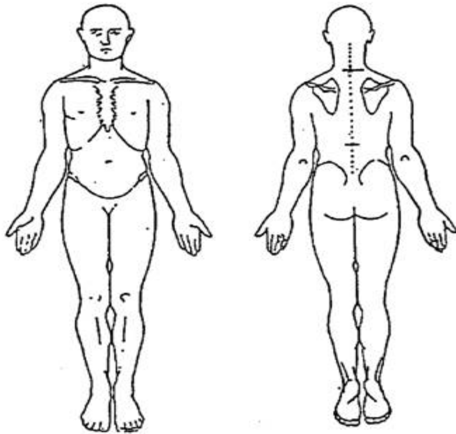
HOW DID YOU HEAR ABOUT US?
A Friend, Family or Co-worker – What's Their Name? __________________________________
Internet I Drive by the office Other:____

BUILDING YOUR HEALTH TEAM
We would like to keep you primary care physician (PCP) informed of your health status. It is our policy to send a brief description of our initial exam and plan of care to your (PCP) following your initial visit. Do you consent to have this information sent to your PCP? Yes No
PCP's Name: ____ Office Ph: (____)_____-______
Office Address: ___________________________ City: ______________ State: ___ Zip: __________

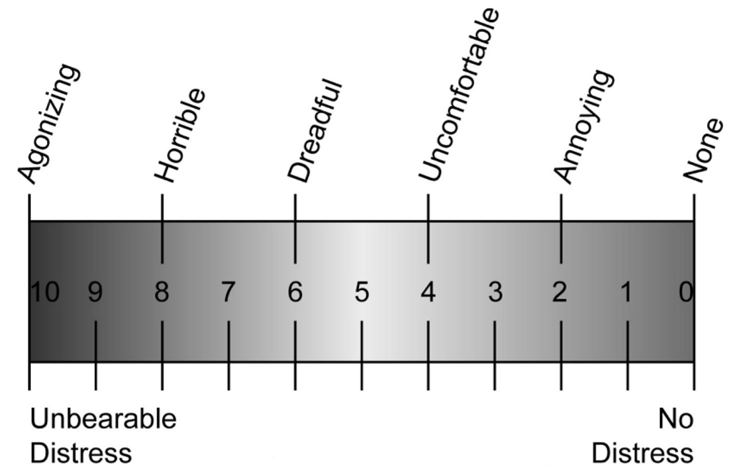
PRESENT COMPLAINTS

Primary Complaint (if you have no complaints please write N/A)
How did it start? ______________________________
When did it start? ______________________________
What makes it feel better? ______________________________
What makes it feel worse? ______________________________
Describe the sensation (dull/sharp/burning/etc): ______________________________
Does the problem radiate to any other parts of the body? Yes No
If "Yes", where? ______________________________
Does it feel worse at a certain time of day? Yes No If "Yes", when? ______________

Please indicate the location of your primary complaint below:



Please indicate your level of discomfort along the scale:



Other Complaints (please describe any other complaints here):______________________________
____
____
____

List any doctors or therapists that you have seen for these complaints:

Doctor/Therapist	Specialty	Result

Please describe any injuries or operations you have had	Approx. date (mm/yy)

Medication/Supplement	Reason for taking	Start date