JACK P. ZANGARA, D.C. ***Date:_____***

PATIENT HEALTH QUESTIONAIRE

Name: _____Date of Birth:_____

Have you had previous Chiropractic care? YES NO

What is your major complaint/ injury?_____

Have you had any Diagnostic Imagining? YES NO Where?:_____

Are your injuries accident related? YES NO AUTO WORK OTHER: _____

When did you problem begin?_____

Since your symptoms began, they have: (circle all that apply)

Increased Decreased Stayed the same

Your symptoms are: Always present Frequent Occasional On and off

How bad is your pain or ache? 1 2 3 4 5 6 7 8 9 10

Describe your pain: Sharp Shooting Dull/Ache Stiff Tingling Numbness Burning

Throbbing Knife-Like Other_____

What makes your symptoms better?_____

What makes your symptoms worse?_____

Other Doctors who treated this condition? _____

List any surgeries:_____

Current Medications:_____

Allergies: _____

Have you been hospitalized in the last 5 years? YES NO When/Why?_____

Have you been diagnosed with Diabetes YES NO If yes, TYPE I TYPE II

EXERCISE: NONE MODERATE DAILY HEAVY

WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR

HABITS: SMOKING ALCOHOL COFFEE/CAFFEINE DRINKS HIGH STRESS

<u>Please check to indicate if you have any of the following:</u>

( ) Weight gain or loss
( ) Decreased hearing
( ) Earaches
( ) Ringing in ears
( ) Blurry/Double vision
( ) Sinus pain

( ) Nausea/Vomiting
( ) Abdominal pain
( ) Diarrhea
( ) Kidney Stones
( ) Constipation
( ) Burning/Pain w/urination

( ) Weakness
( ) Numbness
( ) Tremor
( ) Stroke
( ) Ease of bruising
( )

Nervousness/Anxiety

( ) Blood in urine
( )Shortness of breath
( )High blood pressure
( )Palpatations
( )Aortic Aneurysm
( )Heartburn

( ) Blood in urine
( ) Incontinence
( ) Calf pain w/walking
( ) Leg cramping
( ) Dizziness
( ) Seisures

( ) Depression
( ) Hallucinations
( ) Prostrate issues

<u>Please mark your areas of discomfort:</u>

INSURANCE INFORMATION:

******** Please provide Insurance card(s) and Driver's License or Photo ID ********

PRIMARY INSURANCE: _____ ***POLICY #:***_____

NAME OF INSURED AND DATE OF BIRTH::_____

INSURED EMPLOYER:_____

SECONDARY INSURANCE:_____***POLICY #:***_____

NAME OF INSURED AND DATE OF BIRTH: _____

INSURED EMPLOYER:_____

We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services at time of visit, unless other arrangements have been made. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the provider to release any information required to process/secure insurance claims/benefits, and I assign all applicable insurance benefits directly to JACK P. ZANGARA, D.C.. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient or Legal Representative:_____

Date:_____
(Revised 08/2023)