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: (check 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*

Please check to indicate if you have any of the following:

( ) Weight gain or loss
( ) Decreased hearing
( ) Earaches
( ) Ringing in ears
( ) Blurry/Double vision
( ) Sinus pain
( ) Blood in urine
( ) Shortness of breath
( ) High blood pressure
( ) Palpatations
( ) Aortic Aneurysm
( ) Heartburn

( ) Nausea/Vomiting
( ) Abdominal pain
( ) Diarrhea
( ) Kidney Stones
( ) Constipation
( ) Burning/Pain w/ urination
( ) Incontinence
( ) Calf pain w/walking
( ) Leg cramping
( ) Dizziness
( ) Seizures

( ) Weakness
( ) Numbness
( ) Tremor
( ) Stroke
( ) Ease of bruising
( ) Nervousness/Anxiety
( ) Depression
( ) Hallucinations
( ) Prostrate issues

Please note your areas of discomfort:

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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)