## Chiropractic Health Center of Hamburg

## PatientHealth Questionaire

	Social Security#				_Date	
Name	City		State		Zip	
Street PO Box		_City	State		Zip	
PO Box Birthdate//		Llomo phone	#	Business		
3irthdate//	_Age_		onse #			
Cell phone #		Drivers Lici	Duagnant () Male	() Female ()		
Single ( ) Married ( ) D	ivorced (	) Separated ( )	Pregnant () Maic	() Temate ()		
Present Complaints/Sy	mptoms	E	-mail address			
Description of your cor	idition_					
Date of onset		How did it s	tart			
How often are vour svi	nntoms i	present				
() Constant (76-100% of day)	() Frequen	et (51-75% of day)	Occasional (26-50% of d	ay) () Intermitte	ent (0-25% of day)	
Describe your sympton	ne					
() Sharp () Dull Ache	( )	Numb () Tingling (	) Burning () Other			
What makes it weres						
() Sitting () Standing () Bending	ng ( ) Twistir	ng() Walking() Liftir	ig ( ) Coughing/Sneezing (	) Other		
What makes it hetter						
( ) Le ( ) Heat ( ) Stretching ( )	Walking ( ) !	Sitting ( ) Laying on sic	de/ stomach/ back ( ) Othe	r		
Pain Scale No	ne< 1	2 3 4 5 6	7 8; 9 10 >t	nbearable		
Past Health History		( ) Arthritis	( ) Broken Bones	() Gout		
() Asthma () Aller		( ) Constipation	( ) Diabetes	() Leg Pain		
( ) Cancer ( ) Colit		( ) Herniated Disc	( ) Sciatica	() Heartburn	( ) Headaches	
( )	Back Pain	() Carpal Tunnel	() Chronic Ear Ache	( ) Other		
() Scoliosis () Low	Duen I am					
Type Of Payment: ( Person's Name on Policy:	) Insurance	( ) Worker's Comp.	( ) Auto Accident (	) Medicare ( ) Ca Birthda	ash ite	
How did you hear about or	ur Office?	A Friend? P	lease list their name			
( ) PhoneBook ( ) Insu	rance Book	( ) Val-Pak Coupon	( ) Radio Advertismer	nt		
Who can we contact in case	of Emergen	cy: Name				
Address:			Phone Numbers:			
I authorize the release of medic for services rendered. I underst Although fees for services are of of fees, I acknowledge that pay	tand that I am t due and payme	financially responsible for a ent expected at the time se	rvices are rendered. If I have b	IOI all Sci flood i diletti	ent de la companya de	
IF YOU ARE A MEDICARE RI	ECIPIENT: edicare Progra ay, Including b	im to be made directly to D	r. Peter B. Karas on my behalf. ce, annual deductible, services	I agree to pay any bal not covered or rejecte	ance due which d for any reason.	
IF YOU ARE COVERED BY II	e to Dr. Peter B	B. Karas directly for covere	d services. I agree to pay any a	amount the ins. co. did	not or will not pay.	
l also agree to pay all collect	ion fees, cou	rt costs, attorney fees and	d interest fees accrued with t	he collection of this	account.	
			Patient Signature	Date		
Pagnancible Party	ŗ	Date	rationic signature			

Responsible Party

Date