Chiropractic Health Center of Hamburg

Patient Health Questionnaire

Name_____ **Social Security #**_____/_____/_____ **Date**_____

Street_____ **City**_____ **State**_____ **Zip Code**_____

PO Box_____ **City**_____ **State**_____ **Zip Code**_____

Birthdate_____/_____/_____ **Age**_____ **Home Phone #**_____ **Cell** _____

Driver License #_____ **Email address**_____

( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Pregnant ( ) Male ( ) Female

Present Complaints/Symptoms

Description of your condition_____

Date of onset_____ How did it start_____

How often are your symptoms present?

( ) Constant (76-100% of the day) ( ) Frequent (51-75% of the day) ( ) Occasional (25-50% of the day) ( ) Intermittent (0-25% of the day)

Describe your symptoms

( ) Sharp ( ) Dull Ache ( ) Numb ( ) Tingling ( ) Burning ( ) Other_____

What makes it worse?

( ) Sitting ( ) Standing ( ) Bending ( ) Twisting ( ) Walking ( ) Lifting ( ) Coughing/Sneezing ( ) Other_____

What makes it better?

( ) Ice ( ) Heat ( ) Stretching ( ) Walking ( ) Sitting **Laying on** ( ) side ( ) stomach ( ) back ( ) Other_____

Pain Scale **None < 1 2 3 4 5 6 7 8 9 10 > Unbearable**

Past Health History

( ) Asthma	( ) Allergies	( ) Arthritis	( ) Broken Bones	( ) Gout	( ) Emphysema
( ) Cancer	( ) Colitis	( ) Constipation	( ) Diabetes	( ) Leg Pain	( ) Flat Feet
( ) Neck Pain	( ) Hernia	( ) Herniated Disc	( ) Sciatica	( ) Heartburn	( ) Headaches
( ) Scoliosis	( ) Low Back Pain	( ) Carpal Tunnel	( ) Chronic Ear Ache	( ) Heart	( ) Pacemaker/Defibrillator

Other_____

Type Of Payment: ( ) Insurance ( ) Worker's Comp. ( ) Auto Insurance ( ) Medicare ( ) Cash

Person's Name on Policy:_____ SS# _____/_____/_____ Date of Birth _____/_____/_____

How did you hear about our office? A friend or family member? Please list their name _____

( ) Website ( ) Sign ( ) Google ( ) Phone Book ( ) Insurance Company

Emergency contact: Name _____ Relationship to patient:_____

Address: _____ Phone Number:_____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of benefits to Dr. Peter B. Karas for services rendered. I understand that I am financially responsible for and hereby guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered. If I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

IF you are a Medicare recipient:

I request payment under the Medicare Program to be made directly to Dr. Peter B. Karas on my behalf. I agree to pay any balance due which Medicare does not or will not pay, including but not limited to co-insurance, annual deductible, services not covered or rejected for any reason. I understand the total amount due is my responsibility until the total amount due is satisfied.

If you are covered by insurance:

I request all payments be made to Dr. Peter B. Karas directly for covered services. I agree to pay any amount the insurance company did not or will not pay, I also agree to pay all collection fees, court costs, attorney fees and interest fees accrued with the collection of this amount.

_____ _____

Responsible Party **Date** **Patient Signature** **Date**