

WOOLBRIGHT SPINE & REHAB
2309 W. Woolbright Road
Suite #5
Boynton Beach, Florida 33426
(561) 739-5393

Patient Health Questionnaire

Name: _____ Age: _____ Date of Birth: _____
Address: _____ City/State: _____ Zip: _____
SS#: _____ Home Phone: _____ Cell Phone: _____
Email: _____ Marital Status: M S D W Children: Yes No
Spouse's Name: _____ Your Occupation: _____ Employer: _____
Date of Accident: _____ Time of Accident: _____ Attorney: Yes No
If Yes, Attorney Name: _____ Attorney Phone: _____
Have you been to a Chiropractic Physician before? Yes No Physician Name: _____
Primary Care Physician: _____ May we let your PCP know you are treating with us? Yes No

All Patients must complete this section

Chief Complaint: _____

Have you seen another physician for this condition? Yes No If yes, Physician Name: _____

Is it possible you are pregnant? Yes No Are you taking Nutritional supplements/Medication? Yes No

If yes, what medication/vitamin supplements? _____

Please select all choices that apply to the Patient/Family:

- Abdominal Pain Bulimia Fainting Irritable Colon PMS Sickle Cell Anemia
 Allergies Cancer Kidney Disease Polio Sinus Trouble Angina Headaches
 Kidney Stones Spinal Disc Disorder Anorexia Convulsions Heart Disease
 Liver Disease Prostate Disease Stroke Arthritis High BP Lung Disease
 Asthma Dizziness HIV/AIDS MS Scoliosis Ulcer Blood Disorder
 Osteoporosis Breast Disorder Sex Transmitted Diseases OTHER _____

Patient Exercises: Rarely Moderately Regularly Never

Patient Smokes: 0-1 Pack per day 2 Packs per day Never

Patient uses alcohol: Rarely Moderately Regularly Never

Medications: _____

Allergies: Dust Penicillin Pollen Sulfa Drugs Dander Dairy Products

Latex Perfumes 2ndary Smoke _____

I understand and agree that insurance policies are an arrangement between my insurance carrier and myself. I also understand that this office will prepare all necessary report and the amount authorized to be paid directly to this office will be credited to my account upon receipt. This direction to pay shall not be considered an assignment of benefits as such terms is used in Florida Statute 627.756. I understand that all services rendered to me are charged directly to me and I am personally responsible for payment if my insurance company refuses to pay the claims in a timely manner. (45 days from initial filing shall be considered a timely manner)

Patient's Signature _____ **Date** _____

Guardian's Signature _____ **Date** _____