

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Diane G. Zemba D.C.
430 West Main Street Suite 1
Babylon, New York 11702
631-669-1345

PATIENT INFORMATION

File No. _____

REFERRED BY: _____

1. LAST NAME _____ FIRST NAME _____ 3. MI _____

4. ADDRESS _____ **EMAIL ADDRESS** _____

5. CITY _____ 6. STATE _____ 7. ZIP _____

8. HOME (_____) _____ 9. WORK (_____) _____ 10. CELL (_____) _____

11. AGE ____ 12. DATE OF BIRTH ____/____/____ 13. SEX M F 14. SOC. SEC.# ____ - ____ - ____

15. MARITAL STATUS S M D W 16. SPOUSE'S NAME _____

18. **PRIMARY CARE PHYSICIAN:** _____

ADDRESS: _____

TELEPHONE: (_____) _____ FAX: (_____) _____

EMPLOYMENT INFORMATION

2. **EMPLOYER & OCCUPATION** _____

2. ADDRESS _____

3. CITY _____ 4. STATE _____ 5. ZIP _____

8. BUSINESS PHONE # (_____) _____ 9. FAX # (_____) _____

10. DO YOU HAVE: SURGICAL REPORTS X-RAY REPORTS MRI REPORTS

AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. **INSURANCE TYPE:** AUTO WORK LIEN _____

2. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD _____

3. DATE OF INJURY _____ 4. DESCRIBE HOW INJURY OCCURED? _____

6. WHICH BODY PART(S) WERE INJURED? _____

7. NAME OF INS. CO. _____ 8. INS. PHONE (_____) _____

9. INS. CO. ADDRESS _____

10. POLICY # _____ 11. CLAIM # _____ 12. WCB # _____

13. DID YOU REPORT INJURY? NO YES IF YES, TO WHOM? _____

14. HOSPITALIZED? NO YES WHERE? _____ 15. X-RAYS TAKEN NO YES BY WHOM _____

16. WHERE YOU WORKING AT THE TIME OF THE ACCIDENT? NO YES

17. ARE YOU PRESENTLY WORKING? NO YES IF NO, DATES LOST FROM WORK _____

18. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY _____

19. IF AUTO INJURY, WERE YOU? DRIVER PASSENGER PEDESTRIAN _____

20. # OF PEOPLE IN YOUR VEHICLE? ____ 21. WORE SEAT BELT? NO YES 22. DID AIRBAG INFLATE NO YES

23. **NAME OF ATTORNEY** _____

ATTORNEY ADDRESS: _____

ATTORNEY TELEPHONE: (_____) _____ ATTORNEY FAX: (_____) _____

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. **INSURED'S NAME** _____ 2. INSURED'S SS# ____/____/____

3. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD _____

4. NAME OF INSURANCE CO. _____

5. ADDRESS _____

6. INSURANCE PHONE # (_____) _____ 7. POLICY # _____

SECONDARY INSURANCE 8. INSURED'S NAME _____ 9. SS # ____/____/____

10. NAME IS INSURANCE CO. _____ DOB ____/____/____

11. ADDRESS _____

12. INSURANCE PHONE # (_____) _____ 8. POLICY # _____

Confidential Patient Questionnaire

Diane G. Zemba D.C.
 430 West Main Street Suite A
 Babylon, New York 11702
 631-669-1345

Patient Name: _____ File No. _____ Date: _____

Major Complaint(s): _____

CHECK YOUR PRESENT AND PAST SYMPTOMS					
Present	Past		Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Middle Back Pan	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Fainting, Visual Problems, Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with Bladder/Bowels
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Shoulder, Arms, Elbows	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Hands	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Pain in lower Leg	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle/Foot	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Stiffness in Joints	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Ringling in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Ulcers

Please describe your current pain: Sharp Dull Aches Sore Weak Throbbing
 Shooting Constricting Burning Tingling

Was your problem from a: Car Accident Work Related Injury Started Gradually Slip and Fall Other

Describe how the problem began: _____

What treatment have you received for this condition: Family Doctor Chiropractic Physical Therapy
 Medical Specialist Surgery Injections X-Ray MRI Other _____

Have you ever had this problem before? Yes No

What makes the problem better? Nothing Lying Down Walking Sitting Other _____

What makes the problem worse? Nothing Lying Down Walking Sitting Other _____

Are you currently working? Yes No

If yes, do you: Sit more then 50% of the day Light Manual Labor Heavy Manual Labor

Does Your Problem Affect Your Daily Activities? No Mild Moderate Significant Restrictions

Describe: _____

Do you Smoke? No Yes ___Packs per Day Do you Drink Alcohol? No Socially Habitually

Patient or Legal Guardian Signature _____

Confidential Patient Questionnaire

Diane G. Zemba D.C.
 430 West Main Street Suite A
 Babylon, New York 11702
 631-669-1345

Patient Name: _____ File No. _____ Date: _____

Are you Pregnant? ___No ___Yes Date of Onset of Last Menstrual Period _____

Are you Currently Taking Medication? ___No ___Yes Please List all Medications _____

Do you have Any Allergies to Drugs or Other Products? ___No ___Yes

Describe: _____

FAMILY HISTORY

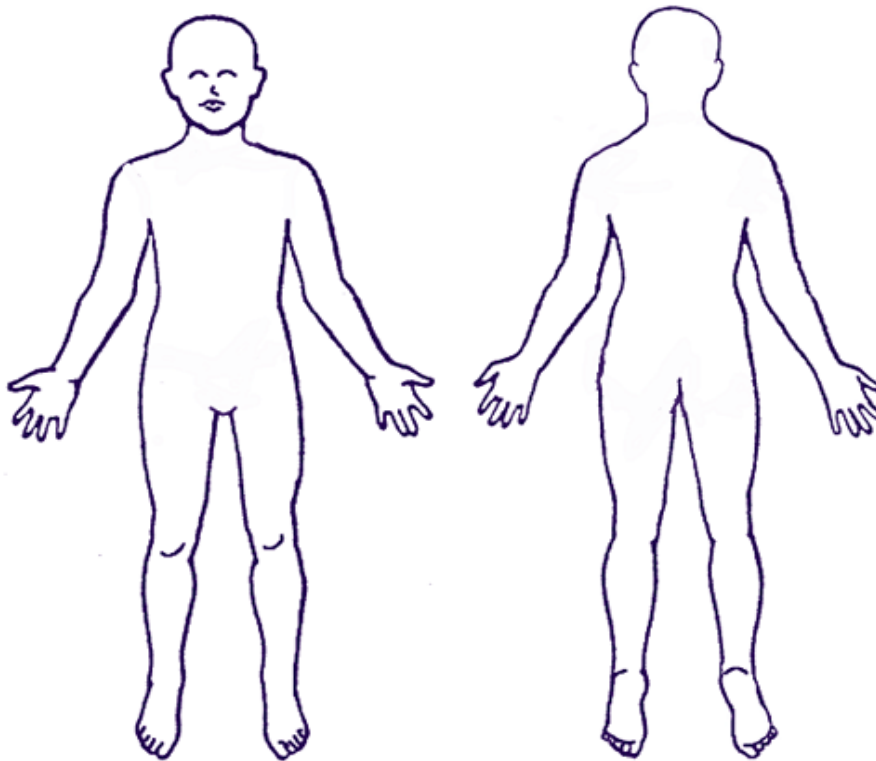
	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Work Status:

- I Have Not Missed Any Days of Work
- I Have Missed ___ Days of Work
- I Have Been Put on Light Duty at Work
- I Have Had to Change my Job as a Result of my Condition

PAIN / SYMPTOM PICTURE

Please mark with an "X" where you have any symptoms



Patient or Legal Guardian Signature _____

Confidential Patient Questionnaire

Page 4 of 4

Diane G. Zemba D.C.
430 West Main Street Suite A
Babylon, New York 11702
631-669-1345

Patient Name: _____

File No. _____

Date: _____

ASSIGNMENT OF BENEFITS AND RIGHTS AND FINANCIAL RESPONSIBILITY

- Assign Benefits
- Assign Rights
- The patient is responsible for collection fees
- Authorize the release of information
- Agree to pay your fees in full if insurance does not pay

Patient's Signature

—

—