DURRETT CHIROPRACTIC & Natural Healthcare Clinic
A Wellness Center

CONFIDENTIAL HEALTH QUESTIONNAIRE

PATIENT INFORMATION *- IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK*

Services in our office are delivered in a manner that goes above and beyond those found in any other office. Part of this service is a thorough, all-inclusive history. Please provide the requested information so that we can help you to the best of our ability.

PATIENT INFORMATION

FULL NAME:_____ DATE OF BIRTH: _____ / _____ / _____ AGE: _____

NAME YOU WOULD LIKE TO BE CALLED, IF DIFFERENT: _____ SSN: _____ - _____ - _____ □ M □ F

ADDRESS: _____ APT #:_____ HOME PH: _____

CITY: _____ STATE: _____ ZIP: _____ CELL PH: _____

MARITAL STATUS: □ SINGLE □ MARRIED □ WIDOWED □ DIVORCED □ OTHER _____ # of Children: _____

SPOUSE / PARTNER'S NAME: _____ EMERGENCY CONTACT #: _____

EMAIL ADDRESS: _____

It is imperative that we have a current email address for all of our patients. This is how we do most of our Office/Patient communication.

REFERRAL SOURCE: The majority of our practice members come from referrals.

WERE YOU REFERRED BY A PATIENT OF OURS? □ YES □ NO PATIENT NAME: _____

WERE YOU REFERRED BY YOUR MD? IF SO, WHO? _____

IF YOU WERE NOT REFERRED BY A PATIENT OR YOUR MD, HOW DID YOU **FIRST** HEAR ABOUT US? ☐FRIEND/FAMILY ☐DRIVE-BY/SIGN ☐MAIL ☐CHAMBER ☐MAGAZINE ☐WEBSITE/DRDURRETT.COM ☐ONLINE SEARCH, i.e. GOOGLE ☐OTHER _____

I WILL BE PAYING TODAY BY: □ CASH □ CHECK □ CREDIT CARD □ HEALTH INSURANCE □ AUTOMOBILE INSURANCE □ WORKER'S COMPENSATION

EMPLOYMENT

EMPLOYER'S NAME: _____ WORK PHONE: _____

OCCUPATION: _____ EMPLOYMENT STATUS: □ FULL TIME □ PART TIME □ RETIRED □ UNEMPLOYED

INSURANCE INFORMATION

INSURED'S NAME: _____ RELATIONSHIP? □ SELF □ SPOUSE □ CHILD □ OTHER _____

INSURED'S EMPLOYER: □ SAME AS ABOVE □ OTHER: _____

INSURED'S SSN: □ SAME AS ABOVE _____ - _____ - _____ INSURED'S DOB: □ SAME AS ABOVE _____ / _____ / _____

PRIMARY INSURANCE CO. _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE #: _____

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE CO. _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE #: _____

POLICY #: _____ GROUP #: _____

WHAT BROUGHT YOU TO OUR OFFICE TODAY?

PLEASE DESCRIBE PRESENT MAJOR COMPLAINT OR HEALTH ISSUESS:

PLEASE RATE YOUR SYMPTOMS OF PAIN OR DISCOMFORT (1-10, WITH 1 LEAST SERIOUS)

1. _____ DISCOMFORT / PAIN LEVEL: _____ ONSET DATE: _____
2. _____ DISCOMFORT / PAIN LEVEL: _____ ONSET DATE: _____
3. _____ DISCOMFORT / PAIN LEVEL: _____ ONSET DATE: _____
4. _____ DISCOMFORT / PAIN LEVEL: _____ ONSET DATE: _____

REGARDING YOUR MAIN COMPLAINT:

SYMPTOMS DEVELOPED FROM: □AN AUTO ACCIDENT ON: _____ □ A JOB RELATED INJURY ON: _____ □AN INJURY ON: _____
□AN ILLNESS □GRADUAL ONSET □AN UNKNOWN ORIGIN

SYMPTOMS HAVE PERSISTED FOR: _____ SYMPTOMS ARE WORSE IN: □THE MORNING □EVENING □UNCHANGED
SYMPTOMS: □COME & GO □ARE CONSTANT □ARE NEARLY CONSTANT □AFTERNOON □CONSISTENT

SELF & FAMILY HISTORY: (S = SELF, M = MOTHER, F = FATHER)

S M F AIDS	S M F DEPRESSION	S M F IS DECEASED	S M F REPRODUCTIVE DISORDER
S M F ALLERGIES	S M F DIABETES	S M F KIDNEY DISORDER	
S M F ANEMIA	S M F DIARRHEA	S M F LOSS OF BOWEL CONTROL	S M F RHEUMATIC FEVER
S M F ARTHRITIS	S M F DIGESTIVE DISORDER	S M F LUNG DISEASE	S M F RHEUMATISM
S M F ASTHMA	S M F DISLOCATED JOINTS	S M F MENSTRUAL CRAMPS	S M F SCARLET FEVER
S M F BACK PAIN	S M F EPILEPSY	S M F MULTIPLE SCLEROSIS	S M F SERIOUS INJURY
S M F BLADDER TROUBLE	S M F FIBROMYALGIA	S M F MUSCULAR DISTROPHY	S M F SINUS TROUBLE
S M F BONE FRACTURE	S M F GERMAN MEASLES	S M F NECK PAIN	S M F TUBERCULOSIS
S M F CANCER	S M F HEADACHES	S M F NERVOUSNESS	S M F VENEREAL DISEASE
S M F CHEST PAIN	S M F HEART TROUBLE	S M F NONE STATED	S M F ADD / ADHD
S M F CONCUSSION	S M F HEPATITIS	S M F NUMBNESS	S M F ADRENAL FATIGUE
S M F CONSTIPATION	S M F HIGH BLOOD PRESSURE	S M F OSTEOPOROSIS	S M F BLOOD SUGAR ISSUES
S M F CONVULSIONS	S M F HIGH CHOLESTEROL	S M F POLIO	S M F TOXICITY ISSUES
S M F DECEASED	S M F HIV / ARC	S M F POOR CIRCULATION	

ACTIVITIES THAT AGGRAVATE:

□ BENDING	□ LIFTING	□ SITTING AFTER _____ MINUTES	□ TURNING HEAD
□ COUGHING	□ LYING DOWN	□ SNEEZING	□ TWISTING INJURED AREA
□ DRIVING	□ OVERHEAD ACTIVITIES	□ STANDING	□ WALKING
□ EXERCISING	□ PREPARING FOOD	□ STANDING _____ MINUTES	□ WALKING AFTER _____ MINUTES
□ GETTING UP & DOWN	□ REACHING	□ STANDING STRAIGHT	
□ INCREASED ACTIVITY IN GENERAL	□ SITTING	□ STRAINING AT STOOL	□ OTHER _____

ACTIVITIES / ITEMS THAT RELIEVE

□ BENDING	□ ICE	□ LYING DOWN	□ REACHING	□ SITTING	□ STANDING	□ WALKING
□ HEAT	□ LIFTING	□ MEDICATION	□ RESTING	□ STRETCHING	□ TURNING HEAD	

ADDITIONAL SYMPTOMS:

□ BLURRED VISION	□ FACE FLUSHED	□ LOW RESISTANCE TO COLDS	□ STIFF NECK
□ BUZZING IN EARS	□ FAINTING	□ MUSCLE JERKING	□ STOMACH UPSET
□ COLD FEET	□ FATIGUE	□ NONE	□ STRESS
□ COLD HANDS	□ FEVER	□ NUMBNESS IN FINGERS	□ CHEMICAL SENSITIVITY
□ COLD SWEATS	□ HEAD SEEMS TOO HEAVY	□ NUMBNESS IN TOES	□ DIFFICULTY SLEEPING
□ CONFUSION	□ HEADACHES	□ PINS & NEEDLES IN ARMS	□ WEIGHT GAIN / LOSS
□ CONCENTRATION LOSS	□ INSOMNIA	□ PINS & NEEDLES IN LEGS	□ THYROID ISSUES
□ CONSTIPATION	□ LIGHT BOTHERS EYES	□ RINGING IN EARS	□ WEEPING SPELLS
□ DEPRESSION	□ LOSS OF BALANCE	□ SENSITIVITY TO COLD / DAMP WEATHER	
□ DIARRHEA	□ LOSS OF SMELL		
□ DIZZINESS	□ LOSS OF TASTE	□ SHORTNESS OF BREATH	□ OTHER _____

HOW DO YOU GRADE YOUR **PHYSICAL** HEALTH? □ EXCELLENT □ GOOD □ FAIR □ POOR □ GETTING BETTER □ GETTING WORSE
AND YOUR **EMOTIONAL / MENTAL** HEALTH? □ EXCELLENT □ GOOD □ FAIR □ POOR □ GETTING BETTER □ GETTING WORSE

IF YOU CONSIDER YOURSELF ILL, WHY DO YOU FEEL THAT YOU ARE ILL? _____

IF YOU CONSIDER YOURSELF WELL, WHY DO YOU FEEL THAT YOU ARE WELL? _____

The AMA has found that more than 80% of all health probems are due to stress. Stress affects the nervous system. In our practice, we are interested in evaluating and examining stresses your body can not properly perceive, adapt to or recover from.

These stresses may be PHYSICAL, CHEMICAL or EMOTIONAL/MENTAL in nature.

PHYSICAL STRESS: Please check "P" for Past, "C" for Current (or both if they apply)

FALLS FROM CRIB / BED □ P □ C
FALLS DOWN / UP STEPS □ P □ C
FALLS ON ICE □ P □ C
SPORTS IMPACTS □ P □ C
PHYSICAL FIGHTS □ P □ C
ARMED SERVICES □ P □ C

HAVE YOU BEEN KNOCKED UNCONSCIOUS? □ YES □ NO EXPLAIN: _____

HAVE YOU EVER USED CRUTCHES, A WALKER OR A CANE? □ YES □ NO EXPLAIN: _____

HAVE YOU EVER BROKEN ANY BONES? □ YES □ NO EXPLAIN: _____

HAVE YOU EVER HAD ANY IMPACTS, FALLS OR JOLTS THAT YOU FEEL SPECIFICALLY MAY HAVE INJURED YOUR SPINE? □ YES □ NO

EXPLAIN: _____

HAVE YOU EVER HAD ANY EXTENSIVE DENTAL OR ORTHODONTIAL WORK DONE? □ YES □ NO

EXPLAIN: _____

AUTOMOBILE ACCIDENTS: HAVE YOU (*EVEN AS A PASSENGER AND EVEN IF YOU DO NOT THINK YOU WERE HURT)* BEEN INVOLVED IN A VEHICULAR COLLISION OR NEAR COLLISION? PLEASE LIST APPROXIMATE DATES AND SEVERITY (MILD, MODERATE, SEVERE OR EXTREME).

AUTOMOBILE: _____

_____

BUS, BICYCLE, MOTORCYCLE, TRAIN, AIRPLANE, MO-PED OR OTHER VEHICLES: _____

_____

SPORTS & LEISURE

IN THE PAST, WERE YOU ACTIVE IN SPORTS? □ YES □ NO WHICH ONE(S)? _____

ARE YOU CURRENTLY ACTIVE IN SPORTS? □ YES □ NO WHICH ONE(S)? _____

HAVE YOU BEEN HURT IN ANY OF THESE ACTIVITIES? □ YES □ NO WHEN? _____

DO YOU READ FOR PROLONGED PERIODS? □ YES □ NO DO YOU PLAY A MUSICAL INSTRUMENT? □ YES □ NO

DO YOU HAVE A PARTICULAR POSITION FOR WATCHING TV OR READING? □ YES □ NO DETAILS: _____

DO YOU WEAR: □ GLASSES □ BIFOCALS □ TRIFOCALS □ CONTACT LENSES □ N/A □ OTHER _____

MEDICAL TREATMENT

HAVE YOU EVER BEEN HOSPITALIZED? □ YES □ NO WHEN? _____

IF YES, WHY? _____ WHAT WAS ACTUALLY DONE TO YOU? _____

PLEASE LIST YOUR LAST KNOWN: WEIGHT _____lbs HEIGHT _____ft _____ in BLOOD PRESSURE _____/_____

SURGICAL HISTORY (CONDITION):

1. _____ WHEN: _____
2. _____ WHEN: _____
3. _____ WHEN: _____

ACCIDENT HISTORY

□ JOB □ AUTO □ OTHER 1. _____ WHEN: _____

□ JOB □ AUTO □ OTHER 2. _____ WHEN: _____

□ JOB □ AUTO □ OTHER 3. _____ WHEN: _____

DO YOU STILL HAVE ALL YOUR BODY PARTS? □ YES □ NO IF NO, PLEASE EXPLAIN: _____

HAVE YOU HAD: □ A SPINAL TAP □ PHYSIOTHERAPY □ NECK COLLAR □ SPINAL BRACE □ TRACTION □ HEEL LIFT
□ SPINAL INJECTIONS □ RADIATION TREATMENTS □ CORRECTIVE SHOES OR BARS ON SHOES □ EXTENSIVE DIAGNOSTIC X-RAYS

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? □Yes □No DATE: _____

DESCRIBE CONDITION: _____

EVER HAD A METAL IMPLANT? □ YES □ NO EVER BEEN GUNSHOT? □ YES □ NO

EMOTIONAL / MENTAL STRESS:

FOR EACH OF THE FOLLOWING POTENTIAL SPINAL STRESS SITUATIONS, PLEASE CHECK "P" for Past, "C" for Current (or both if they apply) UNDER THE LEVEL OF TRAUMA SEVERITY.

	MILD P C	*MODERATE* P C	*EXTREME* P C		*MILD* P C	*MODERATE* P C	*EXTREME* P C
CHILDHOOD STRESS	□ □	□ □	□ □	WORK RELATED STRESS	□ □	□ □	□ □
SCHOOL STRESS	□ □	□ □	□ □	STRESS OF COMMUTING	□ □	□ □	□ □
PLAY OR RECREATIONAL	□ □	□ □	□ □	LOSS OF A LOVED ONE	□ □	□ □	□ □
FAMILY STRESS	□ □	□ □	□ □	CHANGE IN LIFESTYLE	□ □	□ □	□ □
PERSONAL RELATIONSHIPS	□ □	□ □	□ □	CHANGE IN VOCATION	□ □	□ □	□ □
STRESS OF BEING SICK	□ □	□ □	□ □	ABUSE	□ □	□ □	□ □

CHEMICAL STRESS:

ARE YOU NOW TAKING ANY DRUG (PRESCRIPTION, OVER-THE-COUNTER OR RECREATIONAL) REGULARLY?

DRUG: _____ DATE PRESCRIBED: _____ REASON: _____

DRUG: _____ DATE PRESCRIBED: _____ REASON: _____

DRUG: _____ DATE PRESCRIBED: _____ REASON: _____

DRUG: _____ DATE PRESCRIBED: _____ REASON: _____

DRUG: _____ DATE PRESCRIBED: _____ REASON: _____

DO YOU CONSUME: ***D*** - CONSUME DAILY, ***W*** - CONSUME WEEKLY, ***M*** - CONSUME MONTHLY)

	D W M		D W M		D W M
ALCOHOL	□ □ □	EGGS	□ □ □	BEEF	□ □ □
COFFEE	□ □ □	CANNED VEGETABLES	□ □ □	POULTRY	□ □ □
TOBACCO	□ □ □	RAW VEGETABLES	□ □ □	FISH	□ □ □
ARTIFICIAL SWEETENERS	□ □ □	FRESH FRUIT	□ □ □	SEAFOOD	□ □ □
SODA	□ □ □	WHOLE GRAINS	□ □ □	WEIGHT CONTROL PILLS	□ □ □
DIET FOOD	□ □ □	DAIRY	□ □ □	ORGANIC FOODS	□ □ □
REFINED SUGAR	□ □ □	FRIED FOODS	□ □ □	DO YOU FAST?	□ YES □ NO

DO YOU OR DID YOU WORK WITH ANY CHEMICAL, FUME, DUST, POWDER OR SMOKE FOR PROLONGED PERIODS? □ YES □ NO

PLEASE EXPLAIN: _____

AUTHORIZATIONS:

A. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case and by any insurance company contractually obliged to make payment to me or you based upon the charges submitted for products and services rendered.

B. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

C. I authorize the doctors and staff of this clinic to examine and treat me as they find necessary. I further authorize clinic personnel to release medical information regarding my care to insurance companies or other professionals if necessary. I certify that all the information I have given is true and correct. I also certify that I am here for the sole purpose of getting better and no other reason.

PATIENT'S SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE: _____ DATE: _____

COMPREHENSIVE REVIEW OF SYSTEMS

The PURPOSE of this questionnaire is to comprehensively evaluate each of your body's organ systems over the last SIX MONTHS.

If the symptom or event has not occurred within the last **6 months**, mark '**N**'
If the symptom or event is **Rare** or **uncommon**, then select '**R**'
If the symptom or event is **Frequent** or **common**, then select '**F**'
If the symptom or event is **persistent**, or your answer is '**YES**', then select '**A**'

N R F A Consume breads / pastas / starches
N R F A Yeast / Fungal problems
N R F A Tickle in your throat
N R F A Cough / spit clear sputum / phlegm
N R F A Unexplained weight loss
N R F A Nervousness or irritability
N R F A Thinning of the skin
N R F A Prostate problems
N R F A A family history of diabetes
N R F A A family history of cancer
N R F A A family history of heart disease
N R F A Alcohol socially
N R F A Alcohol use extensively
N R F A Do you use street drugs
N R F A Drink coffee / soda / ice tea
N R F A Smoke or use tobacco
N R F A Eat fast food
N R F A Eat pre processed / packaged foods
N R F A Consume sweets
N R F A Use artificial sweetners
N R F A Drink cow's milk
N R F A Consume white sugar
N R F A Consume refined carbs
N R F A Consume wheat or gluten
N R F A Consume artificial flavorings
N R F A Very little exercise
N R F A Family or financial stressors
N R F A Rashes
N R F A Roseacea
N R F A Itchy or dry skin
N R F A Oily skin
N R F A Acne
N R F A Eczema
N R F A Psoriasis
N R F A Skin cancer
N R F A Vertigo / dizziness
N R F A Lightheadedness
N R F A Glaucoma
N R F A Cataracts
N R F A Double vision or blurred vision
N R F A Dry or red eyes
N R F A Macular degeneration
N R F A Watery eyes
N R F A Itchy eyes
N R F A Puffy eyes
N R F A Ear infections
N R F A Tooth cavities
N R F A Bad breath
N R F A Runny nose / sneezing
N R F A COPD / lung disease
N R F A Emphysema
N R F A Chronic bronchitis
N R F A Difficulty breathing deeply
N R F A Acute or chronic coughing
N R F A Wheezing with breathing
N R F A Asthma
N R F A Shortness of breath
N R F A Pain when taking a breath
N R F A Difficulty going to sleep
N R F A Hungry all the time
N R F A Can't lose weight

N R F A Can't gain weight
N R F A Slow metabolism
N R F A Overweight
N R F A Gout
N R F A Diabetes
N R F A Metabolic syndrome
N R F A Thyroid problems
N R F A Too much stress / tension
N R F A Heat / cold intolerance
N R F A Cough/spit green-yellowish sputum
N R F A Trouble with edema / swelling
N R F A Early aging
N R F A Trouble sweating
N R F A Fatigue or tired
N R F A Unexplained swellings
N R F A Diabetic medications
N R F A Thyroid medication
N R F A Diuretics
N R F A Erectile dysfunction
N R F A Pre-menopause
N R F A Peri-menopause
N R F A Suffer from PMS
N R F A Breast tenderness
N R F A Vaginal discharge
N R F A Vaginal dryness
N R F A Birth control
N R F A Irregular periods
N R F A Excessive period bleeding
N R F A Athlete's Foot
N R F A Ovarian cysts
N R F A Fibrocystic breasts
N R F A Fertility concerns
N R F A Increase in urination
N R F A Pelvic pain or cramping
N R F A Mood swings
N R F A Bouts of depression
N R F A Manic episodes
N R F A Loosing your memory
N R F A Hot flashes / sweats
N R F A Thinning hair or brittle hair
N R F A Sexually transmitted disease
N R F A Decrease in sex drive
N R F A Pain with sex
N R F A Hormone replacement
N R F A Heart medication
N R F A A heart attack
N R F A Heart surgery
N R F A Chest pain / angina / tightness
N R F A High blood pressure
N R F A A-fib or arrythmias
N R F A Heart problems
N R F A Slow or fast heart beats at rest
N R F A Deep vein thrombosis
N R F A Poor circulation in hands
N R F A Poor circulation in feet
N R F A Concerns about a stroke
N R F A Restless Leg Syndrome
N R F A Bruise easily
N R F A Heart burn or reflux
N R F A Upset stomach

N R F A Belching
N R F A Ulcers
N R F A Pain after eating
N R F A Heartburn medication
N R F A Indigestion or bloating
N R F A Abdominal cramps or pain
N R F A Irritable Bowel Syndrome
N R F A Diarrhea
N R F A Inflammed intestine - "Leaky Gut"
N R F A Dark black / tarry stools
N R F A Blood on the toilet paper
N R F A Chron's Disease
N R F A Ulcerative Colitis
N R F A Colon polyps
N R F A Diverticulitis
N R F A Constipation
N R F A Laxitives
N R F A Urinary tract infections
N R F A Kidney stones
N R F A Blood in your urine
N R F A Bed wetting
N R F A Urinary discharge (abnormal)
N R F A Dark or smelly urine
N R F A Over-active bladder
N R F A Urinary urgency
N R F A Urinary hesitancy
N R F A Headaches or migraines
N R F A Stiffness or muscle spasms
N R F A Bone pains
N R F A Difficulty exercising
N R F A Fibromyalgia
N R F A Chronic fatigue syndrome
N R F A Back pain or neck pain
N R F A Joint pain
N R F A Arthritis
N R F A Rheumatoid arthritis
N R F A Muscle weakness
N R F A Osteoporosis
N R F A Muscle relaxors
N R F A Seizures
N R F A Anti-depressants
N R F A Pain medications
N R F A Multiple sclerosis
N R F A Numbness or tingling
N R F A Poor coordination
N R F A ADD / ADHD learning disorders
N R F A Brain fog - lack of concentration
N R F A Anxiety / anxiousness
N R F A Problems relaxing
N R F A Feelings of worthlessness
N R F A Allergies
N R F A Sick more often
N R F A Swollen glands
N R F A Recently taken antibiotics
N R F A Sclerodermea or Sjogrens disease
N R F A Fever blisters or cold sores
N R F A Warts
N R F A Sore throat
N R F A Cholesterol problems
N R F A Cholesterol medication
N R F A Gall bladder attacks