Confidential Health Information Questionnaire
DRX 9000

This information is needed so we can better serve you. Please fill in all portions of this form. If you need assistance, please ask our front desk assistant and we will be happy to help you.

Name: ____ Date: ____________________

Address: ____

City: ___________________________________ State: ________________ Zip: ____________________

Home Phone: ____________________ Cell Phone: _____________________ SSN: _________________

Age: _________ Date of Birth: ________________ Height: ________________ Weight: ______________

Married? __________ Spouse's Name: ____

Email address: ________________________________ for monthly updates, health tips and office special events. We will never share this email with anyone.

How did you hear about us? ____

Is your current condition (circle): CERVICAL (neck) or LUMBAR (back)

How long have you had this condition? ___________________

What does this condition prevent you from doing? ____

____

____

____

If applicable, are you able to work with this condition? YES NO

Occupation? ____

Our commitment to correct your condition is our top priority. On a scale of 1 -10, (10 being your top priority), please indicate your commitment for correction.

1 2 3 4 5 6 7 8 9 10

I attest that the above information is true and correct to the best of my knowledge. I also understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

I further acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my chart and maintained for six years.

Patient Signature: ____ Date: _______________