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 Amenia
☐ 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** _____