# TQ CHIROPRACTIC
# CONFIDENTIAL PATIENT INFORMATION

(PLEASE PRINT)

**PATIENT:**

Last Name: _____ First Name: _____ Middle: _____

Gender: M F Date of Birth: _____/_____/_____ Age: _____ SSN#: _____

Martial Status: □ Married / □ Single / □ Divorced How many children? _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

EMAIL: _____ REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

---

**SPOUSE or GUARDIAN:**

Last Name: _____ First Name: _____ Middle: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Employer Name: _____

Date of Birth: _____/_____/_____ SSN#: _____

---

**EMERGENCY** (Name and address of nearest relative or friend **not living with you**)

Last Name: _____ First Name: _____ Middle: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Relation to Patient: _____

---

**PAYMENT METHOD:** □ **Cash** □ **Check** □ **Visa** □ **Mastercard**

---

**INSURANCE:**

Insurance Company: _____

Insured's Name: _____ ID/Policy #: _____

Insured's Date of Birth: _____ Insured's Gender: M F

Patient Relationship to Insured: □ **Self** □ **Spouse** □ **Child** □ **Other:**

Workers Compensation _____

Insured's Name: _____ ID/Policy #: _____

**Is there another health Benefit Plan?** □ YES □ NO (If yes, please indicate below)

Insurance Company: _____

Insured's Name: _____ ID/Policy #: _____

Insured's Date of Birth: _____ Insured's Gender: M F

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other:

---

**Patient's Race:** □ White □ Black/African American □ Hispanic □ American Indian □ Asian

□ Chinese □ Filipino □ Japanese □ Korean □ Vietnamese □ Hawaiian or other pacific Islander

□ Samoan □ Other □ Patient Refused to specify

---

**Patient's Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino □ Patient Refused to specify

**Patient's Preferred Language:** □ English □ Spanish □ Vietnamese □ Chinese □ Other: _____

---

**RESPONSIBLE PARTY:** Complete this section if you are not the patient but are responsible for the bill

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Employer Name: _____ Occupation: _____

---

We are committed to providing you with the best possible care. Coinsurance (co-payment) is due at the time services are rendered. Returned checks and balances older than 60 days may be subject to additional collection fees and interest charge of 1.5 percent per month. All returned checks will be charged an additional $25 fee. Not all services are a covered benefit in all contracts. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are the patient's responsibility. If your insurance does not pay within 60 days of the date of service you will be responsible for paying this bill.

**ASSIGNMENT:** I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Further more, I understand that **TQ Chiropractic** 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 **TQ Chiropractic** 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 professional services rendered to me will be immediately due and payable.

I have read all the information above. I hereby assign all insurance benefits to TQ Chiropractic. I understand and agree that I am financially responsible for all charges incurred to my account whether my insurance pays or not. I agree that in the event of non-payment, within 60 days I will be responsible for the bill payment. I will bear the cost of collection or court costs and attorney fees. I certify that all the information is true and correct to the best of my knowledge. I will notify this office of any changes in my health or billing information. A photocopy of this authorization shall be as valid as the original.

**SIGNATURE:** (Patient, Parent, Legal Guardian or Responsible Party)

**Patient / Guardian Signature** _____ Date: _____

# TQ CHIROPRACTIC - ACUPUNCTURE NEW PATIENT FORM

**Patient Name** _____ **Date**_____

Gender: □ M □ F Height: _____ Weight: _____lbs

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old injury ☐ Chronic Pain ☐ Wellness Visit

Describe your current problem(s):

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain ☐ Other _____

Major Complaint(s), in order of significant to you: _____

Are you in pain: ☐ Yes ☐ No Rate your pain with the following scale (how you feel today):

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: ☐ Work ☐ Sports/play ☐ Auto Accident ☐ Routine/Household Activity

When did your condition/accident occur? ___/___/_____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

How often are your symptoms present? Intermittent ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100 % (Constant)

Is your condition getting better with: ☐ Ice ☐ Heat ☐ Medicine

If with medicine, please list medicine being used here: _____

Is your condition interfering with your: ☐ Work ☐ Sleep or ☐ Daily routine?

If so,how: _____

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINTS?** ☐ Yes ☐ No

If yes, when and location? _____

Has this or something similar happened in the past?

☐ Yes ☐ No If yes, please explain: _____

_____

Please list any medications you are currently taking and there uses: _____

_____

_____

_____

Please list any hospitalizations or surgeries with dates and/or any other serious medical condition(s) not listed above:

_____

_____

List any past serious accidents with dates:

_____

Please list anything that you may be allergic to:

_____

Family Health History: ☐ cancer ☐ high blood pressure ☐ heart disease ☐ stroke ☐ diabetes ☐ bone disease

Please list any other condition (s) not listed above: _____

Do you take Supplements or Vitamins? ☐ Yes ☐ No ☐ Do you exercise? ☐ Yes ☐ No _____ hours per week

Are you wearing: □ Shoe lifts □ Inner soles □ Arch Support Are you dieting? □ No □ Yes Since ___/___/___.

Immunizations (please indicate if it's up to date): _____

**Patient Name** _____ **Date**_____

How was your childhood health? _____

Recent Tests: (please indicate test results and date below)

□ Physical □ Cholesterol □ Prostate □ Blood (which?)

□ HIV/STD □ Pap Smear □ mamography Other: _____

Test Results and Date: _____

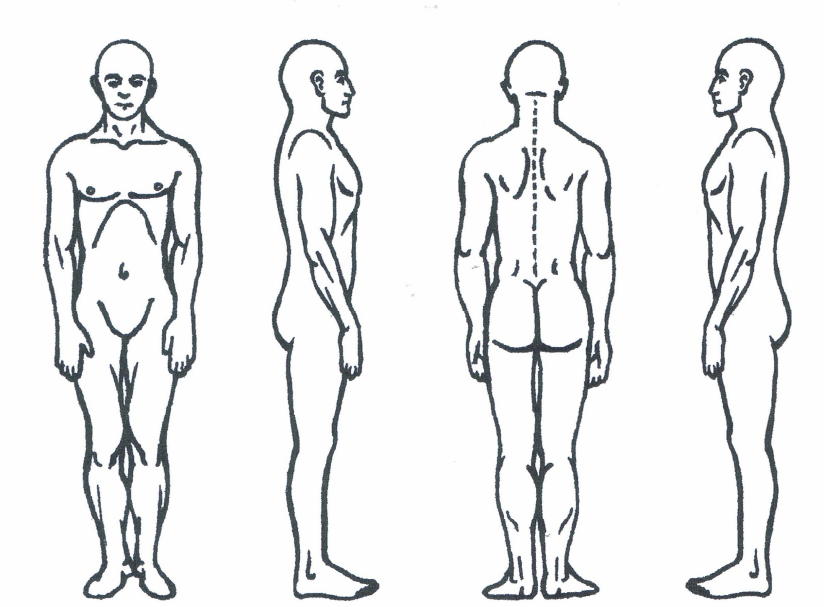
Do you have or have you had any of the following diseases, medical conditions or procedures?

- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Alcohol/Drug Abuse
- ☐ Allergies
- ☐ Anemial/Diabetes
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Implants
- ☐ Artificial valves
- ☐ Bleeding Tendency
- ☐ Cancer / Tumor (explain) _____.
- ☐ Chemotherapy
- ☐ Chicken Pox
- ☐ Congenital Heart Defect
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Emphysema/Asthma
- ☐ Epilepsy
- ☐ Fainting/Seizures/Epilepsy
- ☐ Frequent Neck Pain
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Heart Attack/Stroke (date) _____
- ☐ Heart Murmur
- ☐ Heart/Surg./Pacemaker
- ☐ Hepatitis
- ☐ High Fever
- ☐ High/Low blood pressure
- ☐ HIV / STD
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Lower Back Problems
- ☐ Marked Morning Pain/Stiffness
- ☐ Measles
- ☐ Meningitis
- ☐ Menstrual Problems
- ☐ Migranes
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nervous Disorder
- ☐ Numbness in Groin/Buttocks
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Pain at Night
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Psychiatric problems
- ☐ Recent Fever
- ☐ Rheumatic Fever
- ☐ Severe/Frequent Headaches
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Syphilis
- ☐ Tuberculosis
- ☐ Ulcers/Colities
- ☐ Urinary Problems
- ☐ Venereal Disease
- ☐ Visual Disturbances

☐ other lung illnesses ☐ Other liver illnesses ☐ Other heart illnesses:

☐ Other Kidney Illnesses: ☐ Other:

**Using the adjacent body charts, please mark pain and scar area: (X for pain and circle for scar)**



Is the pain: □ Sharp □ Burning □ Aching

□ Cramping □ Dull □ Moving □ Fixed

□ Other: _____

Do the following lessen the pain?

□Pressure □Cold □ Heat □Exercise

□Other:

Do the following worsen the pain?

□Pressure □Cold □ Heat □Exercise

□Other:

Have you been treated by a medical physician for this pain? ☐ Yes ☐ No

**Patient Name** _____ **Date**_____

Have you ever been treated by a Chiropractor or Acupuncturist? ☐ Yes ☐ No

Clinic or Dr's Name: _____

Clinic phone #: _____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

**Overall Temperature (KD function):**

- ☐ Afternoon flushes
- ☐ Cold body temperature (sensation)
- ☐ Cold Feet
- ☐ Cold Fingers
- ☐ Cold hands
- ☐ Cold Toes
- ☐ Heat in the hands, feet, and chest
- ☐ Hot Body Temperature (sensation)
- ☐ Hot flashes any time of the day
- ☐ lack of perspiration
- ☐ Night sweats
- ☐ perspire easily
- ☐ Sweaty Feet
- ☐ Sweaty Hands
- ☐ Take water to bed
- ☐ Thirsty

**Overall energy (LU, and KD function):**

- ☐ Difficulty keeping eyes open in the daytime
- ☐ Easily catch colds
- ☐ Feel worse after exercise
- ☐ General weakness
- ☐ Low energy
- ☐ Shortness of breath

**Overall blood (LV, SP, HT function):**

- ☐ Dizziness
- ☐ See floating black spots

**HT Function:**

- ☐ Anxiety
- ☐ Chest pain traveling to shoulder
- ☐ Drink coffee (# of cups per week: _____)
- ☐ Frequent dreams
- ☐ Mental confusion
- ☐ Palpitations
- ☐ Restlessness
- ☐ Sores on the tip of the tongue
- ☐ Wake unrefreshed

**LU function:**

- ☐ Allergies (To What? _____)
- ☐ Alternating fever and chills
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Dry mouth
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Dry throat
- ☐ Headache (Location: _____)
- ☐ Nasal discharge (Color: _____)
- ☐ Nose Bleeds
- ☐ Overall achy feeling in the body
- ☐ Sinus Congestion
- ☐ Smoke cigaretteess (# of cigarettes per day: _____)
- ☐ Sneezing
- ☐ Sore throat
- ☐ Stiff neck
- ☐ Stiff shoulders

**SP function:**

- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Easily bruised
- ☐ Fatigue after eating
- ☐ Gurgling noise in the stomach
- ☐ Hemmorrhoids
- ☐ Low appetite
- ☐ Over-thinking
- ☐ Pensive
- ☐ Prolapsed organs (perviously diagnosed, which organ? _____)
- ☐ Worry

**Patient Name** _____ **Date**_____

**SP,ST,LI,SI function:**

- ☐ Blood in stools
- ☐ constipated
- ☐ Diarrhea
- ☐ incomplete
- ☐ Loose
- ☐ Mucous in stools
- ☐ Undigested food in stools

**Dampness trapped in the body:**

- ☐ Chest congestion
- ☐ General sensation of heaviness in the body
- ☐ Mental fogginess
- ☐ Mental heaviness
- ☐ Mental Sluggishness
- ☐ Nausea
- ☐ Snoring
- ☐ Swollen feet
- ☐ Swollen hands
- ☐ Swollen joints

**ST function:**

- ☐ Acid regurgitation
- ☐ Bad breath
- ☐ Belching
- ☐ Bleeding, swollen or painful gums
- ☐ Burning sensation after eating
- ☐ Heartburn
- ☐ Hiccoughs
- ☐ Large appetite
- ☐ Mouth (canker) sores
- ☐ Stomach pain
- ☐ Ulcer (diagnosed)
- ☐ Vomiting

**LV, GB function:**

- ☐ Alternating diarrhea and constipation
- ☐ Anger easily
- ☐ Bitter taste in the mouth
- ☐ Chest pain
- ☐ Convulsions
- ☐ Depression
- ☐ Drink alcohol
- ☐ Frequently unable to adapt to stress (What cause the stress?_____)
- ☐ Frustration
- ☐ Gall stones (history or current)
- ☐ Headache at the top of the head
- ☐ High-pitched ringing in the ears
- ☐ Irritability
- ☐ Limited Range-of-Motion, Neck
- ☐ Limited Range-of-Motion, Shoulder
- ☐ Lump in the throat
- ☐ Muscle cramping
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Neck tension
- ☐ Numbness
- ☐ Recreational drugs (Which _____, How much per week? _____)
- ☐ Seizures
- ☐ Sexually transmitted disease (Which? _____)
- ☐ Shoulder tension
- ☐ Skin rashes
- ☐ Tight sensation in the chest
- ☐ Tingling sensation

**Patient Name** _____ **Date**_____

**Eyes (LV Function):**

- ☐ Bloodshot
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Dry
- ☐ Far-sighted
- ☐ Gritty
- ☐ Hot
- ☐ Itchy
- ☐ Near-sighted
- ☐ Watery

**KD, UB Function:**

- ☐ Bladdar infections
- ☐ Cold sensation in the knees
- ☐ Easily broken bones
- ☐ Easily startled
- ☐ Excessive hair loss
- ☐ Fear
- ☐ Frequent cavities
- ☐ Kidney stones
- ☐ Lack of bladder control
- ☐ Low back pain
- ☐ Low-pitched ringing in the ears
- ☐ Memory problems
- ☐ Sore Knees
- ☐ Wake during the night twice or more to urinate
- ☐ Weak knees

**Urination:**

- ☐ Burning
- ☐ Clear
- ☐ Cloudy
- ☐ Dark yellow
- ☐ Difficult
- ☐ Discharge
- ☐ Frequent
- ☐ Normal color
- ☐ Painful
- ☐ Profuse
- ☐ Reddish
- ☐ Scanty
- ☐ Strong odor
- ☐ Urgent

**Libido:**

- ☐ High
- ☐ Low
- ☐ Normal

**For Men Only:**

- ☐ Feeling of coldness or numbness in external genitalia
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Swollen testes
- ☐ Testicular pain
- ☐ Other: _____

**Patient Name** _____ **Date**_____

**Women only:**

Regular menstrual cycle: □ Yes □ No
Are you pregnant? □ Yes □ No
Are you nursing? □ Yes □ No
Number of children: _____
Age of first menstruation: _____
Average number of days of flow: _____

Are you taking Birth Control? □ Yes □ No
If so, how many weeks? _____
Number of pregnancies: _____
Age of menopause (if applicable): _____
Average # of days of entire cycle: _____

□ Vaginal discharge □ Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

☐ anxiety
☐ breast tenderness
☐ depression
☐ dull pain, where? _____
☐ emotions
☐ food cravings
☐ headaches
☐ irritability
☐ migraines
☐ nausea
☐ sharp pain, where? _____
☐ vomiting
☐ water retention
☐ other

Please fill in the following menstrual chart:

| Color (normal, bright, red, pale, brown, rust, dark, purple, other) | Day 1 | Day 2 | Day 3 | Day4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Amount of flow (normal, heavy, light) | | | | | | | |
| Pain/cramps (location, dull, sharp, other) | | | | | | | |
| Clots (large, small, black, purple, red, other ) | | | | | | | |
| vomiting (check if yes) | | | | | | | |
| Nausea (check if yes) | | | | | | | |
| Other | | | | | | | |

**For all patient, please read and sign below.**

◊ **We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.**

◊ **Our policy requires payment in full for all services rendered at the time of visit, unless other have been made with the business manager. If account is not paid within 60 days of the date of service arrangements and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.**

◊ **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.**

◊ **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

Signature _____ Date _____

☐ Adult patient ☐ Parent or Guardian ☐ Spouse