

CONFIDENTIAL MEDICAL SCREENING QUESTIONNAIRE

Do you presently or have you ever suffered from any of the following? *(Check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Arthritis (eg. rheumatoid) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin disease or sensitivity |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Broken bones / fractures | <input type="checkbox"/> Epilepsy / Seizures |
| <input type="checkbox"/> Allergies: _____ | |

If any of the above apply please provide details: _____

Have you had any surgeries? *(Please list)* _____

Current medications: _____

Do you have a pacemaker?

- Yes No

Do you feel that you have significant stress in your life?

- Yes No

FOR WOMEN: Are you currently pregnant or think you may be pregnant?

- Yes No

What is your major complaint/area of pain? _____

Have you had this or a similar complaint before? _____

Have you had x-rays taken? Yes No If yes, Why? _____ Where? _____

I am **optimistic** that my present problem will improve. *(Please circle one)*

- | | | | | |
|-------------------|----------|------------|-------|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly disagree | Disagree | No opinion | Agree | Strongly Agree |

Signature: _____

Date: _____

BILLING POLICY

The policy for billing is posted in the clinic and is available for viewing. If you have any questions about the billing policy, please ask for clarification from the front desk staff.

I have read and/or understand and agree to the billing policies. I have also had the opportunity to ask questions about these policies. I also understand that these policies may be subject to change without notification.

Signature: _____

(If patient is under 18, parent or guardian must sign)

Date: _____

Staff: _____