## CONFIDENTIAL MEDICAL SCREENING QUESTIONNAIRE

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

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

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: _____ Date:_____
(If patient is under 18, parent or guardian must sign) Staff:_____

*Over* ➪