

**PATIENT QUESTIONNAIRE
Clinic**

Bauman Chiropractic

3613 North Highway 231
Panama City, Fl. 32404

DATE: _____

PATIENT NAME: _____ DOB: _____
SS# _____ E-MAIL: _____

PHONE: (HOME) _____ (WORK) _____ (CELL) _____
PHYSICAL ADDRESS: _____ CITY: _____
STATE: _____ ZIP CODE: _____

EMPLOYER: _____ OCCUPATION: _____

MARITAL STATUS: M S D W Sep. SPOUSE NAME: _____
(circle one)

IN CASE OF EMERGENCY NOTIFY: _____ PHONE: _____
RELATIONSHIP: _____ ADDRESS: _____

WHO IS RESPONSIBLE FOR YOUR BILL? SELF SPOUSE PARENT/GUARDIAN
 EMPLOYER OTHER: _____

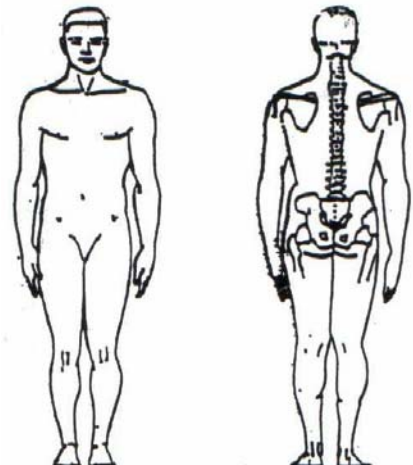
MEDICAL INSURANCE CARRIER _____ ID# _____
NAME OF INSURED _____ DOB _____ SS# _____

IS THIS INJURY DUE TO AN AUTOMOBILE ACCIDENT? YES NO
DATE OF ACCIDENT _____ STATE ACCIDENT OCCURRED _____
WERE YOU AT FAULT? _____ NAME OF INSURED _____
AUTOMOBILE INSURANCE CARRIER _____
PHONE # _____ CLAIM # _____

IS THIS A WORK RELATED INJURY? YES NO DATE OF ACCIDENT _____
WORK COMP. INSURANCE CARRIER _____
CLAIM # _____ ADJUSTER _____
PHONE # _____

DO YOU HAVE A PRESCRIPTION? CHIROPRACTIC PHYSICAL THERAPY
(not required)

PLEASE DESCRIBE YOUR PRIMARY COMPLAINT



PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM.
ALSO DESCRIBE THE FREQUENCY OF YOUR PAIN AND ANY ACTIVITY
THAT INCREASES OR AGGRAVATES YOUR PAIN.