

**The Chiropractic & Sports Injury Center of Cincinnati**  
**Mark A. Korchok D.C., DACBSP**

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Dear Patient: Please complete the questionnaire. Your answers will help determine if we can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case. Thank you.

Social Security # \_\_\_\_\_  
Drivers License # \_\_\_\_\_  
Date \_\_\_\_\_  
E-mail Address \_\_\_\_\_

Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status: M S W D Children? \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Patient's Nearest Relative \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

Referred By \_\_\_\_\_

*To help us better explain chiropractic and how we may be able to help you, please check the one best answer for each statement. (All answers are correct. You're merely expressing your preference.)*

1. I remember important things in my life by: \_\_\_ what I see \_\_\_ what I hear \_\_\_ what I feel
2. The primary reason I brush my teeth is to: \_\_\_ avoid tooth decay and gum disease  
\_\_\_ make sure I have healthy teeth and gums
3. When I make decisions, I generally: \_\_\_ gather the facts and weigh the evidence  
\_\_\_ make the right choice instantly  
\_\_\_ consult my friends and family  
\_\_\_ depend upon how I "feel" about it

Have you had previous chiropractic care? \_\_\_ Yes \_\_\_ No. If yes, Where? \_\_\_\_\_

When? \_\_\_\_\_ Why? \_\_\_\_\_ Where x-rays taken? \_\_\_ Yes \_\_\_ No

Present reason for consulting the office: \_\_\_ disease and symptoms \_\_\_ preventing disease and symptoms  
\_\_\_ maximizing personal health potentials \_\_\_ improving family and/or community health.

What is your major complaint? \_\_\_\_\_

Other Complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Same or similar conditions in the past?  Yes  No

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with your:  Work  Sleep  Daily Routine  Other? \_\_\_\_\_

Other doctors who have treated this condition: \_\_\_\_\_

Please list surgical operations and years: \_\_\_\_\_

Medication that you take: \_\_\_\_\_

Please list your allergies: \_\_\_\_\_

Have you been in an automobile accident?  Yes  No When? \_\_\_\_\_

Please describe \_\_\_\_\_

Have you ever suffered from (please check if yes):  Dizziness  Backaches  Heart Conditions

Diabetes  Lung Conditions  Arthritis  Headaches  Digestive Disorders  Cancer

Sinus Problems  Nervousness and Anxiety  Asthma  Attention Deficit Disorder

Family Health Information (Many health problems can be hereditary. Therefore information about your family members will give us a better picture of your total health.)

Name	Relation	Past & Present Health Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____

#### INSURANCE INFORMATION:

Is your condition related to an automobile accident or job related injury?  Yes  No

Name of Health Insurance Company \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_ Policy Holder's Company \_\_\_\_\_

Are you covered by Medicare?  Yes  No Policy # \_\_\_\_\_

*I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that The Chiropractic & Sports Injury Center of Cincinnati 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 The Chiropractic & Sports Injury Center of Cincinnati will be credited to my account on receipt. However, I 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 service rendered to me will be immediately due and payable.*

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment is due upon services rendered. I will be paying by  Cash  Check  Credit Card