

CHIROPRACTIC HEALTH QUESTIONNAIRE

Patient Name _____ Birthdate _____ Date _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone () _____ Cell # () _____ Email _____
 Social Security Number _____ Patient Employed by _____
 Business Address _____ City _____ State _____ Zip _____
 Position _____ Business Phone () _____ Job Type (Circle One) FT PT Temp
 How many hours per week do you work? _____ How long have you had this position? _____ yrs. _____ mo. Married? Y N
 Spouses Name _____ Date of Birth _____ Social Security No. _____
 Spouse Employed By _____ Business Phone () _____
 Business Address _____ City _____ State _____ Zip _____
 Person Responsible for this account _____ How did you hear about us? _____
 Primary Medical Insurance (present card(s) to the chiropractic asst.) _____
 Reason for visit _____

Have you been treated before for this problem? No Yes
 If yes, by Physician Physical Therapist Osteopath Other _____
 What did they say/recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No Unknown
 Are your symptoms constant, or do they come and go? _____ Does it interfere with your Work Sleep Daily routine Recreation
 Activities or movements that are painful to perform Sitting Walking Bending Lying Down
 Other _____

Describe your activities at work (example: sitting, lifting, etc.) _____
 Have you ever had chiropractic care for other problems? Yes No When? _____
 Do you take Muscle relaxers Pain killers Insulin Birth Control Pills Over-the-counter medicines
 Other prescription drugs _____ (Please list all medications you take in the space on the next page)

Date of last: Physical Exam _____ Spinal x-ray _____ Blood Test _____
 Spinal Exam _____ Chest x-ray _____ Urine Test _____
 Dental X-ray _____ MRI, CT-scan, bone scan _____

Sleep _____ hrs./night Do you sleep on your Back Side Stomach Non-job exercise _____ hrs./wk.
 Age of mattress _____ or waterbed _____ Is your bed comfortable? Yes No
 What kind of pillow do you use? Thick Medium Thin None Support
 Do you wear Heel lifts Shoe lifts Arch supports Orthotics, describe _____

CONDITIONS Check (✓) conditions you have had in the past				
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Hernia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tumors & growths
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Polio	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fractures	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Measles	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Goiter	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Gout	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Scarlet Fever	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke	_____

MEDICATIONS List medications you are currently taking	VITAMINS/HERBS/MINERALS
Allergies _____	

GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Chills <input type="checkbox"/> Dental Problems <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Tiredness <input type="checkbox"/> Weight gain	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - flashes <input type="checkbox"/> Vision - halos	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other	<p>WOMEN Only</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other	<p>GENITO URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful Urination	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal
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Date of last menstrual period _____ Date of last pap smear _____
Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____

NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past year.

<p>NECK</p> <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck weakness <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck <input type="checkbox"/> Grinding/popping sounds in neck	<p>SHOULDERS</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="text-align: center; font-size: small;">Right Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in shoulder joint</td> <td style="text-align: center;"><input type="checkbox"/> R <input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain across shoulders</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Can't raise arm</td> <td style="text-align: center;"><input type="checkbox"/> R <input type="checkbox"/> L</td> </tr> <tr> <td style="padding-left: 20px;"><input type="checkbox"/> Above shoulder level</td> <td></td> </tr> <tr> <td style="padding-left: 20px;"><input type="checkbox"/> Over head</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tension in shoulders</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pinched nerve in shoulder</td> <td style="text-align: center;"><input type="checkbox"/> R <input type="checkbox"/> L</td> </tr> </table> <p>MID-BACK</p> <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Mid-back stiffness <input type="checkbox"/> Pain between shoulder blades		Right Left	<input type="checkbox"/> Pain in shoulder joint	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pain across shoulders		<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Above shoulder level		<input type="checkbox"/> Over head		<input type="checkbox"/> Tension in shoulders		<input type="checkbox"/> Pinched nerve in shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	<p><input type="checkbox"/> Pain from front to back <input type="checkbox"/> Muscle spasms in mid-back</p> <p>ARMS & HANDS</p> <table style="width:100%; 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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature	Date
Reviewed by _____ Doctor	Date