

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date _____

Patient name _____ Birthdate _____

Reason for visit _____

Have you been treated before for this problem? No Yes

If yes, by Physician Doctor of Chiropractic Physical Therapist Osteopath Other _____

What did they do and/or recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No Unknown

Is it constant or does it 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 _____

Your Occupation _____
(Describe activities – sitting, lifting, etc.)

Have you ever had chiropractic care for other problems? No Yes When? _____

Do you take Muscle relaxers Pain killers Insulin Birth control pills Over-the-counter meds

Other prescription drugs _____ Please list all medication in the space at bottom of 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? No Yes

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 or have had in the past.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors, growths |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatoid arthritis | |

MEDICATIONS List medications you are currently taking

VITAMINS/HERBS/MINERALS

Allergies _____

Pharmacy Name _____ Phone _____

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>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>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>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>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>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	<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>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
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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 border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in shoulder joint</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain across shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Can't raise arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td> <input type="checkbox"/> Above shoulder level</td> <td></td> <td></td> </tr> <tr> <td> <input type="checkbox"/> Over head</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tension in shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pinched nerve in shoulder</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><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> <input type="checkbox"/> Pain in upper arm <input type="checkbox"/> Pain in elbow <input type="checkbox"/> Pain in forearm <input type="checkbox"/> Pain in hand <input type="checkbox"/> Pain in fingers <input type="checkbox"/> Pins & needles in arm <input type="checkbox"/> Pins & needles in fingers <input type="checkbox"/> Numbness in arm <input type="checkbox"/> Numbness in fingers <input type="checkbox"/> Weakness of arm <input type="checkbox"/> Weakness of hand <input type="checkbox"/> Hands cold	<table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in upper arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> 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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 _____	Date _____
Doctor _____	Date _____