Chiropractic Health Questionnaire

Date _____

Patient Name _____ **Birth date** _____

Reason for Visit _____

Have you been treated before for this problem? ( ) Yes ( ) No

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

Non-job exercise _____ **hrs/week**

Other _____

Your occupation _____

(Describe activities – sitting, lifting, etc.)

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

Do you take ( ) Muscle relaxers ( ) Painkillers ( ) 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**

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 _____

MEDICATIONS List medications you are currently taking	VITAMINS/HERBS/MINERALS
Allergies	
Pharmacy Name Phone	

(OVER)

CONDITIONS Check conditions you have or had in the past.

( ) AIDS
( ) Alcoholism
( ) Anemia
( ) Anorexia
( ) Appendicitis
( ) Arthritis
( ) Asthma
( ) Bleeding Disorders
( ) Breast Lump
( ) Bronchitis
( ) Bulimia
( ) Cancer
( ) Cataracts
( ) Chemical Dependency
( ) Chicken Pox
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Fractures
( ) Glaucoma
( ) Goiter
( ) Gonorrhea
( ) Gout
( ) Heart Disease
( ) Hepatitis
( ) Hernia
( ) Herpes
( ) High Cholesterol
( ) HIV Positive
( ) Kidney Disease
( ) Liver Disease
( ) Measles
( ) Migraine Headache
( ) Miscarriage
( ) Mononucleosis
( ) Multiple Sclerosis
( ) Mumps
( ) Osteoporosis
( ) Pacemaker
( ) Pneumonia
( ) Polio
( ) Prostate Problem
( ) Prosthesis
( ) Psychiatric
( ) Rheumatoid Arthritis
( ) Rheumatic Fever
( ) Scarlet Fever
( ) Stroke
( ) Suicide Attempt
( ) Thyroid Problems
( ) Tonsillitis
( ) Tuberculosis
( ) Tumors, Growths
( ) Thyroid Fever
( ) Ulcers
( ) Vaginal Infections
( ) Venereal Disease
( ) Whooping Cough
( ) Other _____
_____

GENERAL SYMPTOMS Check conditions you currently have or have had in the past year.

GENERAL
( ) Bruise Easily
( ) Chills
( ) Dental Problems
( ) Depression
( ) Difficulty Sleeping
( ) Dizziness
( ) Fainting
( ) Fever
( ) Forgetfulness
( ) Headache
( ) Loss Of Sleep
( ) Loss Of Weight
( ) Nervousness
( ) Numbness
( ) Sweats
( ) Tiredness
( ) Weight Gain

GENITO-URINARY
( ) Blood In Urine
( ) Frequent Urination
( ) Lack Of Bladder Control
( ) Painful Urination

GASTROINTESTINAL
( ) Appetite Poor
( ) Bloating
( ) Bowel Changes
( ) Constipation
( ) Diarrhea
( ) Excessive Hunger
( ) Excessive Thirst
( ) Gas
( ) Hemorrhoids
( ) Indigestion
( ) Nausea
( ) Rectal Bleeding
( ) Stomach Pain
( ) Vomiting
( ) Vomiting Blood

CARDIOVASCULAR
( ) Chest Pain
( ) High Blood Pressure
( ) Irregular Heartbeat
( ) Low Blood Pressure
( ) Poor Circulation
( ) Rapid Heartbeat
( ) Swelling Of Ankles
( ) Varicose Veins

EYE EAR NOSE THROAT
( ) Bleeding Guns
( ) Blurred Vision
( ) Crossed Eyes
( ) Difficulty Swallowing
( ) Double Vision
( ) Earache
( ) Ear Discharge
( ) Hay Fever
( ) Hoarseness
( ) Loss Of Hearing
( ) Nosebleeds
( ) Persistent Cough
( ) Ringing in Ears
( ) Sinus Problems
( ) Vision - Flashes
( ) Vision - Halos

SKIN
( ) Bruise Easily
( ) Hives
( ) Itching
( ) Change in Moles
( ) Rash
( ) Scars
( ) Sore That Won't Heal

MEN Only
( ) Breast Lump
( ) Erection Difficulties
( ) Lump in Testicles
( ) Penis Discharge
( ) Sore On Penis
( ) Other

WOMEN Only
( ) Abnormal Pap Smear
( ) Bleeding Between Periods
( ) Breast Lump
( ) Extreme Menstrual Pain
( ) Hot Flashes
( ) Nipple Discharge
( ) Painful Intercourse
( ) Vaginal Discharge
( ) Other
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

NECK
( ) Pain Neck
( ) Neck Stiffness
( ) Neck Weakness
( ) Pinched Nerve Neck
( ) Neck Feels Out Of Place
( ) Muscle Spasms Neck
( ) Grinding/Popping in Neck

SHOULDERS Right Left
( ) Pain Shoulder Joint ( ) R ( ) L
( ) Can't Raise Arm ( ) R ( ) L
( ) Above Shoulder Level ( ) R ( ) L
( ) Over Head ( ) R ( ) L
( )Pinched Nerve Shoulder( )R ( )L
( ) Pain Across Shoulders
( ) Tension Shoulders

MIDBACK
( ) Mid Back Pain
( ) Mid Back Stiffness
( ) Pain Between Shoulder Blades
( ) Pain From Front To Back
( ) Muscle Spasms in Mid Back

ARMS & HAND Right Left
( ) Pain Upper Arm ( ) R ( ) L
( ) Pain Elbow ( ) R ( ) L
( ) Pain Forearm ( ) R ( ) L
( ) Pain Hand ( ) R ( ) L
( ) Pain Fingers ( ) R ( ) L
( ) Pins/ Needles Arm ( ) R ( ) L
( ) Pins/Needles Fingers ( )R ( ) L
( ) Numbness Arm ( ) R ( ) L
( ) Numbness Fingers ( ) R ( ) L
( ) Weakness Of Arm ( ) R ( ) L
( ) Weakness Of Hand ( ) R ( ) L
( ) Hands Cold ( ) R ( ) L

LOW BACK
( ) Low Back Pain
( ) Low Back Stiffness
( ) Low Back Weakness
( ) Pinched Nerve in Low Back
( ) Low Back Feels Out Of Place
( ) Muscle Spasms in Low Back

HIPS LEGS & FEET Right Left
( ) Pain in Buttocks ( ) R ( ) L
( ) Pain in Hip Joint ( ) R ( ) L
( ) Pain Down Leg ( ) R ( ) L
( ) Pain in Knee ( ) R ( ) L
( ) Pain in Ankle ( ) R ( ) L
( ) Pain in Foot ( ) R ( ) L
( ) Weakness Of Leg ( ) R ( ) L
( ) Weakness Of Knee ( ) R ( ) L
( ) Leg Cramps ( ) R ( ) L

OTHER SYMPTOMS
_____
_____
_____
_____
_____
_____
_____
_____
_____

SURGERIES / HOSPITALIZATION / PROCEDURES

( ) None
( ) Prostate Surgery
( ) Colonostomy
( ) Joint Surgery
( ) Pacemaker
( ) Other _____

( ) Colon Surgery
( ) Colonoscopy
( ) Hysterectomy
( ) Heart Surgery
( ) Appendectomy

( ) Gallbladder Surgery
( ) EGD/ Endoscopy
( ) C- Section
( ) Heart Stent
( ) Blood Transfusions

( ) Hernia Surgery
( ) ERCP
( ) Hiatal Hernia Repair
( ) Defibrillator (AICD
( ) Gastric Bypass Surgery
( ) Orthopedic Surgery

SOCIAL HISTORY - Marital Status
( ) Children ( ) None ( ) How Many
( ) Single ( ) Separated ( ) Married
( ) Divorced ( ) Widowed ( ) Partnered

Social History - Alcohol
( ) Never ( ) More Than Two Days/Week
( ) Rarely ( ) Less Than Two Days/ Week
( ) Daily ( ) I Quit Using Alcohol

Social History -Occupation _____ ( ) Retired

RECREATIONAL DRUGS ( ) None
( ) I Have Used IV Drugs In The Past
( ) I Currently Use Recreational Drugs
( ) I Have Been Treated For Substance Abuse

Social History -Tobacco
( ) I Use Tobacco Products
( ) I Have Never Used Tobacco Products
( ) I Quit Using Tobacco Products

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**