

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date _____
Patient Name _____ Birthdate _____

Reason for visit _____ When did symptoms appear? _____

Event/cause of onset: _____

Is your condition related to employment (current or previous)? Yes No
Is your condition related to auto accident? Yes No Other accident? Yes No

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? _____

Is this condition getting progressively worse? Yes No Unknown
Is it constant or does it come and go? _____

Does it interfere with Work Sleep Daily Routine Recreation
Activities or movements that are painful to perform Sitting Walking Bending
 Lying Down Other _____

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 Meds Other Prescription Drugs _____

Date of last: Physical Exam _____ Spinal X-Ray _____
Spinal Exam _____ Chest X-Ray _____
MRI, CT-scan, bone scan – date and area scanned _____

Sleep _____ hrs/night Do you sleep on your Back Side Stomach
Non-job exercise _____ hrs/wk

- CONDITIONS** (Check mark conditions you currently have. Mark X by conditions you have had in the past)
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tumors, growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate Problem | |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Psychiatric care | |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis | |

MEDICATIONS (List medications you are **currently** taking) _____ Vitamins/Herbs/Minerals _____

Allergies _____

GENERAL SYMPTOMS(Check mark symptoms you currently have. Mark X by symptoms you have had in the last year.)

| | | | |
|--|--|--|--|
| <u>GENERAL</u> | <u>GASTROINTESTINAL</u> | <u>EYE, EAR, NOSE, THROAT</u> | <u>SKIN</u> |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Appetite poor | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Bloating | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Bowel changes | <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Change in moles |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Double vision | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Earache | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Sore that won't heal |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Gas | <input type="checkbox"/> Hay fever | <u>CARDIOVASCULAR</u> |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Nausea | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Rapid Heart Beat |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Vision – flashes | <input type="checkbox"/> Swelling ankles |
| <input type="checkbox"/> Tiredness | <u>GENITO-URINARY</u> | <input type="checkbox"/> Vision – halos | <input type="checkbox"/> Varicose Vein |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Blood in urine | | <input type="checkbox"/> Blood clots WHEN? _____ |
| | <input type="checkbox"/> Frequent urination | | <u>WOMEN ONLY</u> |
| | <input type="checkbox"/> Lack of bladder control | | Date of last menstrual period _____ |
| | <input type="checkbox"/> Painful urination | | Have you had a mammogram? _____ |
| | | | Are you pregnant? _____ |
| | | | Number of Children _____ |

NECK, BACK, EXTREMITIES

(Rate current pain and stiffness on a scale of 0 1 2 3 4 5 6 7 8 9 10.)
 None Little Medium Severe

| | | |
|--|--|--|
| <u>NECK</u> | <input type="checkbox"/> Pain from front to back | <input type="checkbox"/> Low back feels out of place |
| <input type="checkbox"/> Pain in neck | <input type="checkbox"/> Muscle spasms in mid-back | <input type="checkbox"/> Muscle spasms in low back |
| <input type="checkbox"/> Neck stiffness | <u>ARMS & HANDS</u> | <u>HIPS, LEGS & FEET</u> |
| <input type="checkbox"/> Neck weakness | <input type="checkbox"/> Pain in upper arm | <input type="checkbox"/> Pain in buttocks |
| <input type="checkbox"/> Pinched nerve in neck | <input type="checkbox"/> Pain in elbow | <input type="checkbox"/> Pain in hip joint |
| <input type="checkbox"/> Neck feels out of place | <input type="checkbox"/> Pain in forearm | <input type="checkbox"/> Pain down leg |
| <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Pain in hand | <input type="checkbox"/> Pain in knee |
| <input type="checkbox"/> Grinding/popping sounds in neck | <input type="checkbox"/> Pain in fingers | <input type="checkbox"/> Pain in ankle |
| <u>SHOULDERS</u> | <input type="checkbox"/> Pins & needles in arm | <input type="checkbox"/> Pain in foot |
| <input type="checkbox"/> Pain in shoulder joint <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Pins & needles in fingers | <input type="checkbox"/> Weakness of leg |
| <input type="checkbox"/> Pain across shoulders | <input type="checkbox"/> Numbness of arm | <input type="checkbox"/> Weakness of knee |
| <input type="checkbox"/> Can't raise arm <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Above shoulder level | <input type="checkbox"/> Weakness of arm | |
| <input type="checkbox"/> Overhead | <input type="checkbox"/> Weakness of hand | <u>OTHER SYMPTOMS:</u> |
| <input type="checkbox"/> Tension in shoulders | <input type="checkbox"/> Hands Cold | _____ |
| <input type="checkbox"/> Pinched nerve in shoulder <input type="checkbox"/> R <input type="checkbox"/> L | <u>LOW BACK</u> | _____ |
| <u>MID-BACK</u> | <input type="checkbox"/> Low back pain | _____ |
| <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Low back stiffness | _____ |
| <input type="checkbox"/> Mid-back stiffness | <input type="checkbox"/> Low back weakness | _____ |
| <input type="checkbox"/> Pain between shoulder blades | <input type="checkbox"/> Pinched nerve in low back | _____ |

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 _____
