

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? _____

What are your goals relating to Chiropractic care? Pain Relief Prevention of Symptoms Overall Wellness

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 _____

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

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 _____

GENERAL SYMPTOMS Check (✓) symptoms you currently have or 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"/> Tuberculosis
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Polio	<input type="checkbox"/> Tumors, growths
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fractures	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Measles	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Goiter	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Gout	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Other _____
<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.			
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Chills	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dental problems	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Depression	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other
<input type="checkbox"/> Fainting	<input type="checkbox"/> Gas	<input type="checkbox"/> Ear discharge	WOMEN ONLY
<input type="checkbox"/> Fever	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Abnormal pap smear
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Extreme menstrual pain
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Numbness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Sweats	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Tiredness	CARDIOVASCULAR	<input type="checkbox"/> Vision-flashes	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Vision-halos	<input type="checkbox"/> Other
GENITO-URINARY	<input type="checkbox"/> High blood pressure	SKIN	Date of last period _____
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Bruise easily	Date of last Pap Smear _____
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Hives	Have you had a
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Itching	Mammogram? _____
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Change in moles	Are you pregnant? _____
	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Rash	Number of children _____
	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Scars	

NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past.			
NECK	MID-BACK continued		LOW BACK continued
<input type="checkbox"/> Pain in neck	<input type="checkbox"/> Pain from front to back		<input type="checkbox"/> Low back feels out of place
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Muscle spasms in mid-back		<input type="checkbox"/> Muscle spasms in low back
<input type="checkbox"/> Neck weakness	ARMS & HANDS	Right Left	HIPS, LEGS, FEET Right Left
<input type="checkbox"/> Pinched nerve in neck	<input type="checkbox"/> Pain in upper arm	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pain in buttocks <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Neck feels out of place	<input type="checkbox"/> Pain in elbow	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pain in hip joint <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Muscle spasms in neck	<input type="checkbox"/> Pain in forearm	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pain down leg <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Grinding/popping sounds in neck	<input type="checkbox"/> Pain in hand	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pain in knee <input type="checkbox"/> R <input type="checkbox"/> L
SHOULDERS	<input type="checkbox"/> Pain in fingers	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pain in ankle <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Pain in shoulder joint	<input type="checkbox"/> Pins/needles in arm	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pain in foot <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Pain across shoulders	<input type="checkbox"/> Pins/needles in finger	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Weakness of leg <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> Numbness in arm	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Weakness of ankle <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Above shoulder level	<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Leg cramps <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Over head	<input type="checkbox"/> Weakness of arm	<input type="checkbox"/> R <input type="checkbox"/> L	OTHER SYMPTOMS
<input type="checkbox"/> Tension in shoulders	<input type="checkbox"/> Weakness of hand	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Pinched nerve in shoulder	<input type="checkbox"/> Hands cold	<input type="checkbox"/> R <input type="checkbox"/> L	_____
MID-BACK	LOW BACK		_____
<input type="checkbox"/> Mid-back pain	<input type="checkbox"/> Low back pain		_____
<input type="checkbox"/> Mid-back stiffness	<input type="checkbox"/> Low back stiffness		_____
<input type="checkbox"/> Pain between shoulder blades	<input type="checkbox"/> Low back weakness		_____
	<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 _____ Date _____