CHIROPRACTIC HEALTH QUESTIONAIRE

Date: _____

Patient Name _____ Birth date _____

Height _____ Weight _____

Reason for visit _____

Have you been treated for this problem? No Yes, by MD Chiropractor Physical Therapist Other _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Y N Unknown

Is it constant or does it come and go? _____ Does it interfere with your Work Sleep Daily routine Recreation

Your Occupation _____ Date Started _____

Date of last: Physical exam _____ Spinal x-ray _____ Spinal exam _____

Chest x-ray _____ MRI, CT-scan, bone scan _____

Sleep _____hrs/night Do you sleep on your Back Side Stomach

Non-job exercise _____hrs/wk Alcohol _____per week Caffine _____per day

Smoke: ____ Former Smoker ____ Current Smoker ____Never smoker

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 any conditions you or your family members have / or had in the past/.

- **Diabetes:** Self___ Parents___ Siblings___ Maternal Grandparents___ Paternal Grandparents___
- **Kidney disease:** Self___ Parents___ Siblings___ Maternal Grandparents___ Paternal Grandparents___
- **Stroke:** Self___ Parents___ Siblings___ Maternal Grandparents___ Paternal Grandparents___
- **Heart disease:** Self___ Parents___ Siblings___ Maternal Grandparents___ Paternal Grandparents___
- **Cancer:** Self___ Parents___ Siblings___ Maternal Grandparents___ Paternal Grandparents___
- **High blood pressure:** Self___ Parents___ Siblings___ Maternal Grandparents___ Paternal Grandparents___
- **Other:** _____ Self___ Parents___ Siblings___ Maternal Grandparents___ Paternal Grandparents___

Do you have High Blood Pressure Y/N Do you have Diabetes Y/N Blood Pressure: /

MEDICATIONS & Supplements List medications and supplements you are currently taking

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies Please list all allergies and reactions

_____ _____

_____ _____

_____ _____

_____ _____

GENERAL SYMPTOMS Check (✓) SYMPTOMS you currently have.

- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain
- ☐ Blood in the urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Pain urination
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos
- ☐ 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 _____

PREGNANT WOMEN
Number of Weeks:
_____

PREGNANT WOMEN Cont.
Expected Due Date:
_____

OB Provider:
_____

Number of Children:
_____

Have you had...

Vaginal bleeding or Leakage?
Yes / No

Contractions?
Yes / No

Leg Pain?
Yes / No

Fever
Yes / No

Heart Problem or High Blood Pressure
Yes / No

Problems with past pregnancies?
Yes / No

PLEASE MARK areas of pain or injury on the illustrations below and CIRCLE word description of the symptoms you are experiencing in those areas.

Additional comments:

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