

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date _____

Patient name _____ Birth Date _____

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 _____

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 in the past.

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

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

OVER

GENERAL SYMPTOMS: Check (✓) symptoms 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 heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- 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 in neck
- Neck stiffness
- Neck weakness
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding/popping sounds in neck

- Pain from front to back
- Muscle spasms in mid-back

- Low back feels out of place
- Muscle spasms in low back

SHOULDERS

- | | | |
|--|--------------------------|--------------------------|
| | Right | Left |
| <input type="checkbox"/> Pain in shoulder joint | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain across shoulders | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Can't raise arm | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> ED Above shoulder level | | |
| <input type="checkbox"/> El Over head | | |
| <input type="checkbox"/> Tension in shoulders | | |
| <input type="checkbox"/> Pinched nerve in shoulder | <input type="checkbox"/> | <input type="checkbox"/> |

ARMS & HANDS

- Pain in upper arm
- Pain in elbow
- Pain in forearm
- Pain in hand
- Pain in fingers
- Pins & needles in arm
- Pins & needles in fingers
- Numbness in arm
- Numbness in fingers
- Weakness of arm
- Weakness of hand
- Hands cold

Right Left

-
-
-
-
-
-
-
-
-
-
-
-

HIPS, LEGS & FEET

- | | | |
|--|--------------------------|--------------------------|
| | Right | Left |
| <input type="checkbox"/> Pain in buttocks | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain in hip joint | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain down leg | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain in knee | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain in ankle | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain in foot | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Weakness of leg | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Weakness of knee | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> | <input type="checkbox"/> |

L R

MID-BACK

- Mid-back pain
- Mid-back stiffness
- Pain between shoulder blades

LOW BACK

- Low back pain
- Low back stiffness
- Low back weakness
- Pinched nerve in low back

OTHER SYMPTOMS _____

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 _____