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?_____

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_____ Non-job exercise_____hrs/wk
(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.

Family Doctor's Name_____ Phone #_____

Doctor's Address_____City_____State_____Zip_____

Date of last: Physical exam_____ Spinal x-ray_____ Blood test_____

Spinal exam_____ MRI, CT-scan, bone scan_____

Prior surgeries/operations_____
What and When

Prior hospitalizations_____
When/ Where/ Why

Do you have any hobbies_____

Do you ☐ Smoke ☐ Drink alcohol ☐ Use Drugs ☐ _____

CONDITIONS Please check your **current** and/or **past** symptoms and indicate year first noticed.

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

MEDICATIONS List **ALL** medications you are currently taking	**VITAMINS/HERBS/MINERALS**
_____	_____
_____	_____
Allergies_____	_____
Pharmacy _____ Phone_____	_____

over

Patient name_____ Date_____

GENERAL SYMPTOMS Please check your **current** and/or **past** symptoms and indicate year first noticed.

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 Please check your **current** and/or **past** symptoms and indicate year first noticed.

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

SHOULDERS Right Left
- ☐ Pain in shoulder joint ☐ R ☐ L
- ☐ Pain across shoulders
- ☐ Can't raise arm ☐ R ☐ L
  - ☐ Above shoulder level
  - ☐ Over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder ☐ R ☐ L

MID-BACK
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

ARMS & HANDS Right Left
- ☐ Pain in upper arm ☐ R ☐ L
- ☐ Pain in elbow ☐ R ☐ L
- ☐ Pain in forearm ☐ R ☐ L
- ☐ Pain in hand ☐ R ☐ L
- ☐ Pain in fingers ☐ R ☐ L
- ☐ Pins & needles in arm ☐ R ☐ L
- ☐ Pins & needles in fingers ☐ R ☐ L
- ☐ Numbness in arm ☐ R ☐ L
- ☐ Numbness in 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

_____
_____
_____
_____

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