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Chiropractic Health Questionnaire

Patient Name: _____ Date: _____

Birthdate: _____ Occupation: _____

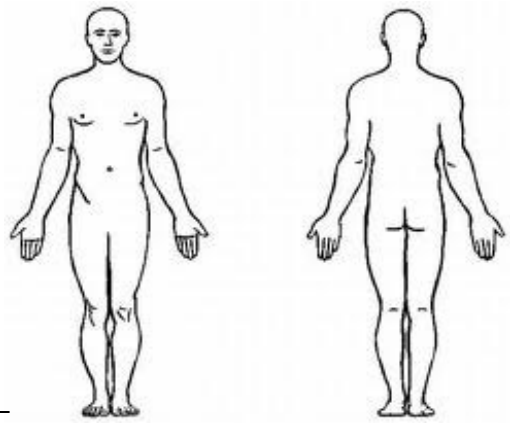
Have you ever had chiropractic care? ☐ Yes ☐ No When?_____

Reason for Today's Visit:

- ☐ Headache
- ☐ Neck Pain
- ☐ Middle Back Pain
- ☐ Lower Back Pain
- ☐ Other _____

_____

Indicate Your Pain with an **X**



What do you believe caused your condition?

_____

_____

When did your symptoms appear? _____

What have you done for treatment for this condition? _____

☐ Nothing ☐ MD ☐ MRI/X-rays ☐ Therapy ☐ Medications (ibuprofen/Tylenol) ☐ Ice ☐ Heat ☐ Other

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Is your pain: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other

Activities or movements that are painful to perform:

☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down ☐ Other _____

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain):

(Circle one) 0 1 2 3 4 5 6 7 8 9 10

(Circle one) Mild Moderate Severe

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Weakness ☐ Other_____

INJURIES/SURGERIES YOU HAVE HAD	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Surgeries		

I certify that the information on both sides of this questionnaire 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 _____

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GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past.

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

- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal
- ☐ Bruising

MEN

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Date of last Physical _____

WOMEN

- ☐ 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? Yes No
Are you pregnant? Yes No (___ weeks)
Number of children _____

CONDITIONS Check (✓) conditions you currently have or have had in the past.

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Concussion
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental/Psychological Disorder/Illness
- ☐ Migraine Headaches
- ☐ Musculoskeletal Disorder/Disease
- ☐ Multiple Sclerosis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Prostate Problem
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumors, Growths
- ☐ Ulcers
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HISTORY

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ _____
- ☐ _____

MEDICATIONS (include dosage)

☐ None ☐ See List Provided

_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS

☐ None ☐ See List Provided

_____
_____
_____
_____
_____
_____

VITAMINS/HERBS

☐ None ☐ See List Provided

_____
_____
_____
_____
_____
_____

EXERCISE

☐ None ☐ Occasional ☐ Daily

☐ Light ☐ Moderate ☐ Intense

Type: _____

HABITS

Smoker: ☐ Yes ☐ No ☐ Former Cigarettes/day ___
Alcohol Intake: ☐ Yes ☐ No Drinks per week ___
Coffee: _____ cups per day
Pop/Soda: _____ bottles/cans per day
Water: _____ ounces per day

ADDITIONAL CONCERNS

☐ Weight Loss ☐ Nutrition

☐ Supplements ☐ Exercise

☐ Other _____