Health Questionnaire

Patient Information

Date: _____
Patient Name: _____ Date of Birth: _____
Height: _____ Weight: _____
Address:
Phone: (Work)
(Cell)
Reason for Appointment:
List all prescription, non-prescription medications and other supplements you take as well as the associated condition:

_____
_____
_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____
_____
List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____
_____
_____

Do you exercise? □ Yes □ No Hours per week _____What activity(s)? _____

Do you participate in any sporting leagues? □ Yes □ No If yes, what sports? _____

How long have you been participating in sports? _____

Are you dieting? □ Yes □ No Since:_____ Do you use tobacco? Y/N _____packs per day.
How many years have you been smoking? _____

Do you drink alcoholic beverages? □ Yes □ No __drinks per day.

What is your occupation? _____

Does your job require physical activity? Y/N
If so, what type of movements/activities? _____

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No; If pregnant, How many weeks? _____
Date of last menstrual period: _____

What are the nutritional goals (if any) that you have set: _____

Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

How often do symptoms occur? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

_____

_____

Have you experienced these symptoms in the past?_____

_____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? Yes/ No

Have you seen a chiropractor before? Yes/ No Who referred you to us? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

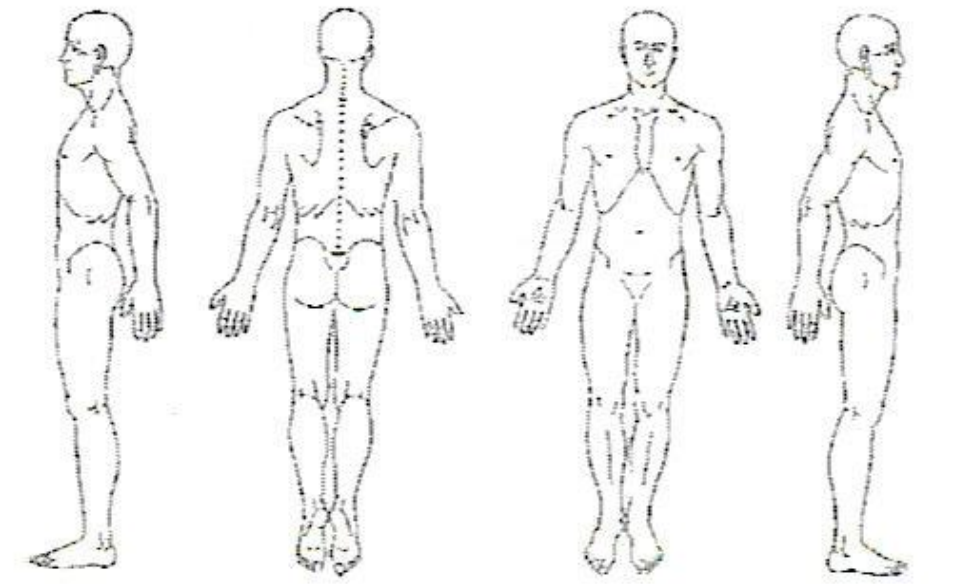
_____

_____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnorm Weight Change	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/ stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know: _____

_____

_____

_____

Patient's signature: _____ **Doctor's signature:** _____

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