

Health Questionnaire

Patient Information

Full Name _____ Date of Birth _____ Height _____ Weight _____

Medical History

Describe the reason for your visit _____

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

How often do you experience your symptoms? Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe your symptoms? Sharp Dull ache Numb Shooting Burning Tingling Stabbing

How are your symptoms changing? Getting better Staying the same Getting worse

Are your symptoms affecting your daily activities? Severe (Unable to Perform) Moderate (Painful/Limited) Mild (Painful/Can Do) No Effect (Discomfort)

On a scale of one to ten how intense are your symptoms? (Not intense) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

History of Treatment

Primary Care Physician _____ Facility _____ Phone _____

Have you seen a Chiropractor before? Yes No If yes, when was your last visit? _____

Have you seen another doctor for these symptoms? If yes, who? _____

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 any allergies _____

Family History (list all major diseases such as cancer, diabetes, heart problems, etc and the relation to you and the individual)

Do you smoke? Yes No If yes, how many packs per day? _____ Are you pregnant? Yes No

Description of Condition

Using the key below, mark on the body diagram where you are experiencing the following symptoms:

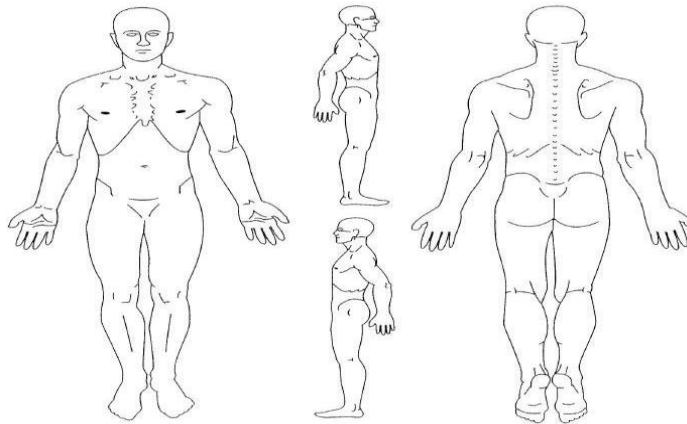
N=Numbness

B=Burning

S=Stabbing

T=Tingling

A=Dull Ache



Review of Systems

(Indicate if you have had conditions in the past or presently have the conditions)

Cardiovascular	Past	Present	Respiratory	Past	Present	Allergic/Immunologic	Past	Present
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
Chest Pain			Cough					
High Cholesterol			Wheezing					
Pace Maker						Ear, Nose and Throat	Past	Present
Jaw Pain /TMJ			Eyes	Past	Present	Difficulty Swallowing		
Irregular Heartbeat			Glaucoma			Dizziness		
Swelling of legs			Double Vision			Hearing Loss		
			Blurred Vision			Sore Throat		
						Nosebleeds		
Genitourinary	Past	Present	Psychiatric	Past	Present	Bleeding Gums		
Kidney Disease			Depression			Sinus Infections		
Burning Urination			Anxiety					
Frequent Urination			Stress			Gastrointestinal	Past	Present
Blood in Urine						Gall Bladder Problems		
Kidney Stones			Endocrine	Past	Present	Bowel Problems		
Lower Side Pain			Thyroid			Constipation		
			Diabetes			Liver Problems		
Neurologic	Past	Present	Hair Loss			Ulcers		
Stroke			Menopausal			Diarrhea		
Seizures			Menstrual			Nausea/Vomiting		
Head Injury						Bloody Stools		
Brain Aneurysm			Hematologic	Past	Present	Poor Appetite		
Numbness			Hepatitis					
Severe Headaches			Blood Clots			Musculoskeletal	Past	Present
Pinched Nerves			Cancer			Gout		
Parkinson's			Bruising			Arthritis		
Carpal Tunnel			Bleeding			Joint Stiffness		
Vertigo			Fever, Chills			Muscle Weakness		
			Sweating			Osteoporosis		
Constitutional	Past	Present				Broken Bones		
Difficulty Sleeping						Joints Replaced		
Weight Loss/Gain								