Health Questionnaire

Patient Name _____ **Date**_____

1. Describe your symptoms _____

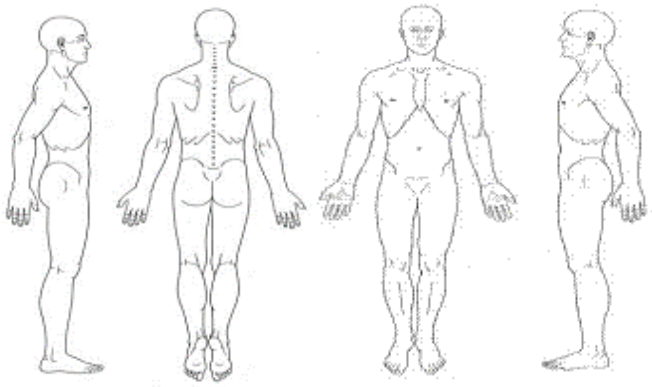
When did your symptoms start? _____

How did your symptoms begin? _____

2. How often do you experience your symptoms? (Select one)

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

3. On the figures on the right, indicate the location of your pain?



4. What describes the nature of your symptoms?
(Select one or more)

☐ Sharp ☐ Dull Ache ☐ Numb
☐ Shooting ☐ Burning ☐ Tingling

5. How are your symptoms changing?

_____ Getting Better _____ Not Changing _____ Getting Worse

6. During the past four weeks: *None* *Unbearable*

How would you rate the average severity of your symptoms? 0 1 2 3 4 5 6 7 8 9 10

How would you rate the severity of your symptoms at their best? 0 1 2 3 4 5 6 7 8 9 10

How would you rate the severity of your symptoms at their worst? 0 1 2 3 4 5 6 7 8 9 10

7. In general, how would you describe your overall health right now? (Circle one)

Excellent Very Good Fair Poor

8. Who have you seen for your symptoms?

☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other _____

What treatment did you receive and when? _____

What tests have you received/when were they performed?

X-rays: date _____ CT Scan: date_____ MRI: date _____ Other: date _____

10. What is your occupation? (Circle one)

☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker
☐ FT Student ☐ Retired ☐ Other _____

11. Health History

A complete understanding of your health status will facilitate your treatment. Please check if you have ever had any of the following?

Have you had any of the following diseases?

☐ Polio ☐ Epilepsy ☐ HIV
☐ Anemia ☐ Alcoholism ☐ Parkinson's
☐ Cancer* ☐ Tuberculosis ☐ MS
☐ Thyroid ☐ Diabetes* ☐ Arthritis
☐ Heart Disease ☐ Hepatitis

Operations

☐ Back Operation*
☐ Gall Bladder
☐ Tonsillectomy
☐ Appendectomy
☐ Thyroid Operation
☐ Rectal Surgery
☐ Hernia
☐ Female Organs

Medications

☐ Prednisone
☐ Cortisone
☐ Other (please list)
_____
_____
_____
_____
_____

Please check the following that apply to you

☐ Experienced minor trauma
☐ Experienced significant trauma (prior to age 20 or after age 50)
☐ Had a recent infection
☐ IV Drug Use (past or present)
☐ Smoking (past or present)
☐ EP Injection*

Do/Did any members of your immediate family (mother, father, sister, brother) have any serious health condition?

☐ No ☐ Yes If yes, please explain _____

Please check the following symptoms/signs which you now or have had in the last 3 – 5 years.

General Symptoms

☐ Headaches
☐ Fever*
☐Chills
☐ Night Sweats
☐ Fainting
☐ Dizziness
☐ Convulsions
☐ Loss of Sleep
☐ Fatigue
☐ Nervousness
☐ Loss of Weight
☐ Numbness or pain in arms, legs or hands
☐ Allergy*
☐ Wheezing
☐ Night Pain*

Gastro-Intestinal

☐ Poor Appetite*
☐ Poor Digestion
☐ Excessive Hunger
☐ Belching or Gas
☐ Nausea
☐ Vomiting
☐ Vomiting of Blood
☐ Pain over Stomach
☐ Constipation*
☐ Diarrhea*
☐ Colon Trouble
☐ Hemorrhoids
☐ Liver Trouble
☐ Gall Bladder Trouble

Eye/Ear/Nose/Throat

☐ Poor Vision
☐ Crossed Eyes
☐ Pain in Eyes
☐ Deafness
☐ Earache
☐ Ear Noises
☐ Nose Bleeds
☐ Sore Throat
☐ Hoarseness
☐ Hay Fever
☐ Asthma
☐ Frequent Colds
☐ Enlarged Thyroid
☐ Tonsillitis
☐ Sinus Trouble
☐ Nasal Discharge

Respiration

☐ Chronic Cough
☐ Spitting up Phlegm
☐ Spitting up Blood
☐ Chest Pain
☐ Difficult Breathing

Genito-Urinary

☐ Frequent Urination*
☐ Painful Urination
☐ Bloody Urine
☐ Kidney Infection
☐ Kidney Stones
☐ Bed Wetting
☐ Inability to Control Urine*
☐ Prostate Trouble*

Muscle & Joints

☐ Weakness
☐ Twitching
☐ Stiff Neck
☐ Backache
☐ Swollen Joints
☐ Tremors
☐ Foot Trouble
☐ Pain between shoulders
☐ Hernia
☐ Spinal Curvature
☐ Faulty Posture

Cardiovascular

☐ Rapid Heart Beat
☐ Slow Heart Beat
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Pain Over Heart
☐ Previous Heart Trouble
☐ Swelling of Ankles
☐ Poor Circulation
☐ Varicose Veins
☐ Stroke (CVA)

Skin

☐ Skin Eruptions
☐ Itching
☐ Bruising
☐ Dryness
☐ Sensitive Skin
☐ Hives (allergy)
☐Eczema
☐ Moles that have changed*

Women Only

☐ Painful Menstrual Period
☐ Excessive Flow
☐ Irregular Cycles
☐ Hot Flashes
☐ Cramps or Backaches
☐ PID (Pelvic Inflammatory Disease)
☐ Lumps in Breast
☐ Painful Intercourse

Please provide additional information for all items checked that include an asterisk (*): _____
_____
_____
_____

Patient Signature _____ **Date** _____