HEALTH QUESTIONNAIRE

Name _____ Phone_____

Address _____ City _____ State _____ Zip _____

Age _____Birth Date _____ Sex ◯ F ◯ M SSN: _____

email address _____

Marital status: single married divorced widowed Spouse's name _____

Children's name(s) and age(s)_____

Emergency contact _____ Phone _____

Employer's Name _____ Employer's Address _____

Who may I thank for referring you to my office? _____

What are your most pressing health concerns? _____

_____

When did it start? _____

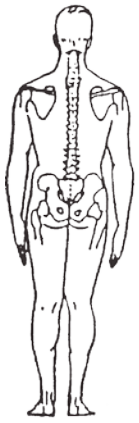
Have you consulted any other doctor / practitioner for this health concern? Y N

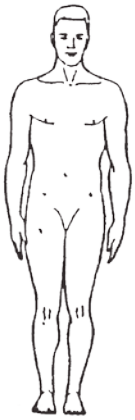
If yes, please write down the date, name and credentials. _____

_____

Are your health concerns... ◯ improving ◯ getting worse ◯ staying the same

Where is the problem? Please use the illustrations and lines below to explain.





Front:_____

_____

_____

_____

_____

Back:_____

_____

_____

_____

Is your pain:.. ☐ burning ☐ dull ☐ sharp ☐ shooting ☐ aching ☐ throbbing ☐ tingling ☐ aches

When do you feel your pain: ☐ constantly ☐ frequently ☐ intermittently ☐ occasionally

Are your symptoms affected by: ☐ standing ☐ sitting ☐ bending ☐ walking ☐ lying down ☐ weather

Do your symptoms interfere with: ☐ work ☐ day-to-day activities ☐ sleep ☐ play ☐ energy

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please give name of drug, reason for taking it and for how long you've been taking it _____

_____

On a scale of 1-10 (1=least, 10=most), please rate the severity of your current symptoms

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

Information about Your Health History

Do you have, or have you had, any of the following (please check all that apply)

☐ pneumonia	☐ mumps	☐ influenza	☐ rheumatic fever	☐ smallpox
☐ pleurisy	☐ polio	☐ chicken pox	☐ thyroid disease	☐ diabetes
☐ epilepsy	☐ cancer	☐ depression	☐ whopping cough	☐ anemia
☐ eczema	☐ measles	☐ arthritis	☐ heart disease	☐ rashes

Have you ever suffered from (please check all that apply)

☐ neck pain	☐ laryngitis	☐ irregular heart beat	☐ dazed / confused
☐ blurred vision	☐ tonsilitis	☐ excessive thirst	☐ fainting
☐ headache	☐ coughing	☐ vomiting	☐ paralysis
☐ migraines	☐ tennis elbow	☐ low back pain	☐ weight loss
☐ arm back/tingling	☐ dental problems	☐ irritable bowel	☐ confusion
☐ shoulder pain	☐ Mid-back pain	☐ black or bloody stools	☐ nervousness
☐ fatigue	☐ shortness of breath	☐ colitis	☐ excessive appetite
☐ hand pain/tingling	☐ difficulty breathing	☐ constipation	☐ depression
☐ cold extremities	☐ breast pain/lump	☐ hemorrhoids	☐ loss of sleep
☐ jaw pain	☐ heartburn	☐ liver problems	☐ numbness
☐ vision problems	☐ chest pain	☐ prostate problem	☐ skin conditions/ acne / pimpels
☐ ear pain	☐ lung problems	☐ ankle swelling	☐ blood sugar problems
☐ sinus problems	☐ heart problems	☐ leg pain/tingling	☐ knee pains
☐ allergies	☐ abnormal blood pressure	☐ bladder trouble	☐ shin splints
☐ difficulty hearing	☐ gas/bloating after meals	☐ excessive urination	☐ kidney conditions
☐ runny nose	☐ painful menstruation	☐ discolored urine	☐ gallbladder problems
☐ stroke	☐ Asthma	☐ Jaundice	☐ haital hernia

Past injuries can affect present health (please check all that apply)

☐ falls/accidents	☐ head injuries	☐ fights	☐ sport injuries	☐ broken bones
☐ dislocations	☐ spinal tap	☐ surgery	☐ traction	☐ use(d) a cane or walker
☐ extensive dental work		☐ dental appliances		☐ knocked unconscious

If yes to any of the above, please describe _____

_____

Information About Your Lifestyle

Are you active in any exercise and/or sport activities? Yes ◯ No ◯

If yes, please describe _____

How would you rate your eating habits? ☐ excellent ☐ pretty good ☐ could be better ☐ needs improvement

Do you follow a specific nutritional program? ◯ Yes ◯ No

If yes, please describe _____

Have you ever taken any kind of antiobiotics? ◯ Yes ◯ No

If yes, please write down dates and reason for medication _____

_____

Do you smoke? ◯ Yes ◯ No If yes, how much? _____

How many hours per week do you generally work? ◯ 20 hrs ◯ 30 hrs ◯ 40 hrs ◯ 50 hrs ◯ 60 hrs

How well do you sleep? ◯ excellent ◯ pretty good ◯ restless ◯ I can't sleep

How is your energy overall? ◯ full power ◯ okay ◯ low ◯ sporadic

Do you feel your immune system is... ◯ strong ◯ okay ◯ low

Do you wake up... ◯ full of energy ◯ feeling rested ◯ feeling tired ◯ feeling exhausted

Do you take any nutritional supplements and/or vitamins? ◯ Yes ◯ No

If yes, please write down what kind, the brand name and for how long you've been taken them _____

_____

Women Only: Do you take birth control pills? ◯ Yes ◯ No

Do you take hormone replacement medication? ◯ Yes ◯ No

Information about You and Chiropractic

Have you ever been to a chiropractor before? ◯ Yes ◯ No

If yes, who was the chiropractor? _____

Why did you seek chiropractic care? _____

For how long did you receive chiropractic care? _____

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? ◯ Yes ◯ No

If yes, please describe _____

_____

What do you hope to receive from chiropractic? _____

_____

Information about Your Financial Responsibilities

Who is responsible for payment?

_____

How will you pay for your care? cash check credit card # _____

Exp. _____ Insurance Co. _____

Group policy # _____ Address: _____

Phone _____

Insured's Name _____ Subscriber ID# _____

The above is accurate to the best of my knowledge.

_____ _____

Patient's Signature Date