Back In Action Chiropractic LLC ▪ 10443 Illinois Road ▪ Fort Wayne, IN 46814 ▪ (260) 625.5144

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date_____

Patient name_____ Birthdate_____

Reason for visit_____

Have you been treated before for this problem? ☐ No ☐ Yes

If yes, by ☐ Physician ☐ Doctor of Chiropractic ☐ Physical Therapist ☐ Osteopath ☐ Other_____

What did they do and/or recommend?_____

When did your symptoms appear?_____ Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Is it constant or does it come and go?_____Does it interfere with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Other_____

Your Occupation_____ Non-job exercise_____hrs/wk

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes If yes, when and what problem?_____

Do you take ☐ Muscle relaxers ☐ Pain killers ☐ Insulin ☐ Birth control pills ☐ Over-the-counter meds ☐ Other prescription drugs

Date of last: Physical exam_____ Spinal x-ray_____ Blood test_____

Spinal exam_____ Chest x-ray_____ Urine test_____

Dental x-ray_____ MRI, CT-scan, bone scan_____

Name of your Medical Doctor _____

Do you sleep on your ☐ Back ☐ Side ☐ Stomach Age of mattress_____or waterbed_____ Is your bed comfortable? _____

What kind of pillow do you use? ☐ Thick ☐ Medium ☐ Thin ☐ None ☐ Support Sleep _____hrs/night

Do you wear ☐ Heel lifts ☐ Shoe lifts ☐ Arch supports ☐ Orthotics, describe_____

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

☐ AIDS	☐ Cataracts	☐ Hepatitis	☐ Mumps	☐ Suicide attempt
☐ Alcoholism	☐ Chemical dependency	☐ Hernia	☐ Osteoporosis	☐ Thyroid problems
☐ Anemia	☐ Chicken pox	☐ Herpes	☐ Pacemaker	☐ Tonsillitis
☐ Anorexia	☐ Diabetes	☐ High cholesterol	☐ Pneumonia	☐ Tuberculosis
☐ Appendicitis	☐ Emphysema	☐ HIV positive	☐ Polio	☐ Tumors, growths
☐ Arthritis	☐ Epilepsy	☐ Kidney disease	☐ Prostate problem	☐ Typhoid fever
☐ Asthma	☐ Fractures	☐ Liver disease	☐ Prosthesis	☐ Ulcers
☐ Bleeding disorders	☐ Glaucoma	☐ Measles	☐ Psychiatric care	☐ Vaginal infections
☐ Breast lump	☐ Goiter	☐ Migraine headaches	☐ Rheumatoid arthritis	☐ Venereal disease
☐ Bronchitis	☐ Gonorrhea	☐ Miscarriage	☐ Rheumatic fever	☐ Whooping cough
☐ Bulimia	☐ Gout	☐ Mononucleosis	☐ Scarlet fever	☐ Other _____
☐ Cancer	☐ Heart disease	☐ Multiple sclerosis	☐ Stroke	_____

MEDICATIONS List medications you are currently taking	**VITAMINS/HERBS/MINERALS**
_____	_____
_____	_____
_____	_____
Allergies_____	_____

SURGERIES List surgeries and approximate dates	**TRAUMAS** List traumas and approximate dates
_____	_____
_____	_____

GENERAL
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain/loss

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ 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
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last period _____
Date of last Pap Smear_____
Have you had a Mammogram?_____
Are you pregnant? _____
Number of children_____

NECK, BACK, EXTREMITIES

NECK
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS	**Right**	**Left**
☐ Pain in shoulder joint	☐ R	☐ L
☐ Pain across shoulders		
☐ Can't raise arm	☐ R	☐ L
☐ Above shoulder level		
☐ Over head		
☐ Tension in shoulders		
☐ Pinched nerve in shoulder	☐ R	☐ L

MID-BACK
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades

MID-BACK continued
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

ARMS & HANDS	**Right**	**Left**
☐ Pain in upper arm	☐ R	☐ L
☐ Pain in elbow	☐ R	☐ L
☐ Pain in forearm	☐ R	☐ L
☐ Pain in hand	☐ R	☐ L
☐ Pain in fingers	☐ R	☐ L
☐ Pins/needles in arm	☐ R	☐ L
☐ Pins/needles in finger	☐ R	☐ L
☐ Numbness in arm	☐ R	☐ L
☐ Numbness in fingers	☐ R	☐ L
☐ Weakness of arm	☐ R	☐ L
☐ Weakness of hand	☐ R	☐ L
☐ Hands cold	☐ R	☐ L

LOW BACK
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back

LOW BACK continued
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

HIPS, LEGS, FEET	Right	Left
☐ Pain in buttocks	☐ R	☐ L
☐ Pain in hip joint	☐ R	☐ L
☐ Pain down leg	☐ R	☐ L
☐ Pain in knee	☐ R	☐ L
☐ Pain in ankle	☐ R	☐ L
☐ Pain in foot	☐ R	☐ L
☐ Weakness of leg	☐ R	☐ L
☐ Weakness of ankle	☐ R	☐ L
☐ Leg cramps	☐ R	☐ L

OTHER SYMPTOMS

_____
_____
_____
_____
_____
_____
_____
_____

I certify that the above information 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_____