

**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 \_\_\_\_\_

| <b>GENERAL SYMPTOMS</b> Check symptoms you currently have or have had in the past. |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> AIDS  | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Suicide attempt    |
| <input type="checkbox"/> Alcoholism  | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Chicken pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia  | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> HIV positive       | <input type="checkbox"/> Polio                    | <input type="checkbox"/> Tumors, growths    |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Prostate problem         | <input type="checkbox"/> Typhoid fever      |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Liver disease      | <input type="checkbox"/> Prosthesis               | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding disorders  | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Psychiatric care         | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Breast lump   | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Rheumatoid arthritis     | <input type="checkbox"/> Venereal disease   |
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatic fever          | <input type="checkbox"/> Whooping cough     |
| <input type="checkbox"/> Bulimia   | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Scarlet fever            | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke                   |   |
| <b>MEDICATIONS</b> List medications you are currently taking                       |  |   | <b>VITAMINS/HERBS/MINERALS</b>                    |   |
| _____  |  |   | _____   |   |
| _____  |  |   | _____   |   |
| Allergies _____  |  |   | _____   |   |
| <b>SURGERIES</b> List surgeries and approximate dates                              |  |   | <b>TRAUMAS</b> 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**

- |  |                            |                            |
|--|----------------------------|----------------------------|
|  | <b>Right</b>               | <b>Left</b>                |
| <input type="checkbox"/> Pain in shoulder joint    | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain across shoulders     |                            |                            |
| <input type="checkbox"/> Can't raise arm           | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Above shoulder level      |                            |                            |
| <input type="checkbox"/> Over head                 |                            |                            |
| <input type="checkbox"/> Tension in shoulders      |                            |                            |
| <input type="checkbox"/> Pinched nerve in shoulder | <input type="checkbox"/> R | <input type="checkbox"/> 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**

- |   |                            |                            |
|---|----------------------------|----------------------------|
|   | <b>Right</b>               | <b>Left</b>                |
| <input type="checkbox"/> Pain in upper arm      | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in elbow          | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in forearm        | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in hand           | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in fingers        | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pins/needles in arm    | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pins/needles in finger | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Numbness in arm        | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Weakness of arm        | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Weakness of hand       | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Hands cold             | <input type="checkbox"/> R | <input type="checkbox"/> 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**

- |  |                            |                            |
|--|----------------------------|----------------------------|
|  | <b>Right</b>               | <b>Left</b>                |
| <input type="checkbox"/> Pain in buttocks  | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in hip joint | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain down leg     | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in knee      | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in ankle     | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in foot      | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Weakness of leg   | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Weakness of ankle | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Leg cramps        | <input type="checkbox"/> R | <input type="checkbox"/> 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 \_\_\_\_\_