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? ____

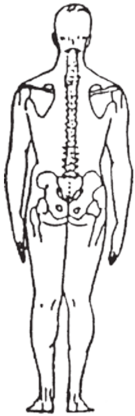
Have you consulted any other doctor / practitioner for this health concern? Y N

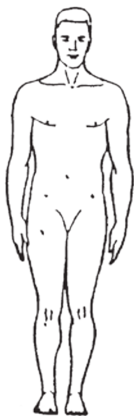
If yes, please write down the date, name and credentials. ___________________________________

____

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

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





Front:____

____

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____

____

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 rake 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