



Health Questionnaire

Patient Information

Patient Name: _____ Date of Birth: ____/____/____ Height: _____ Weight: _____

Medical History

Describe the reason(s) for your doctor visit today:

When did your symptoms start? _____ How did your symptoms begin? _____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? _____

Have you experienced these symptoms in the past? _____

On a scale of one to ten how intense are your symptoms? Not intense ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ___ No

Have you seen a chiropractor before? ___Yes ___ No If yes, when was your last visit? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

List any surgeries or hospitalizations you have had complete with the month and year for each:

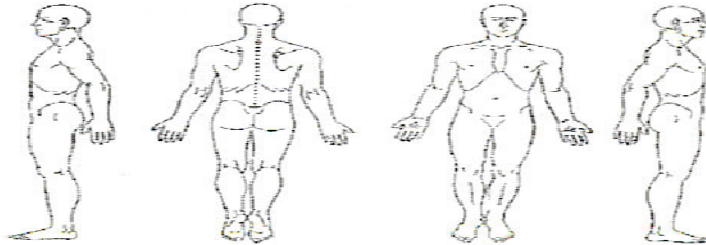
List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual): _____

Do you smoke? Yes No _____ packs per day. Are you pregnant? Yes No

Description of Condition

Please circle the area(s) of discomfort:



Left

Back

Front

Right

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Elbow/upper arm pain	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder
<input type="radio"/>	<input type="radio"/>	Abnormal Weight gain/loss	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control
<input type="radio"/>	<input type="radio"/>	Allergies Headache	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Low back pain
<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>	Mid back pain
<input type="radio"/>	<input type="radio"/>	Ankle/foot pain	<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Neck pain
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Hand pain	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Shoulder pain
<input type="radio"/>	<input type="radio"/>	Birth Control Pills	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Smoking/tobacco Use
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Hip/upper leg pain	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Systematic Lupus
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Thoracic Outlet Syndrome
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Jaw pain	<input type="radio"/>	<input type="radio"/>	Tumor
<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Joint swelling/stiffness	<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Upper back pain
<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Knee/lower leg pain	<input type="radio"/>	<input type="radio"/>	Wrist pain

Patient's signature: _____ Doctor's signature: _____