CHIROPRACTIC HEALTH QUESTIONNAIRE

Full Name: _____ Date: _____

Reason for Visit: _____

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

If yes, **when and how** did the issue start? _____

_____

Who treated? ☐ Physician. ☐ Chiropractor ☐ P.T ☐ Osteopath ☐ Acupuncturist ☐ Other: _____

What was done/recommended? _____

Is it getting worse? ☐ Yes ☐ No ☐ Unsure | Is it constant or does it come and go? _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation: _____

Activities/Movements painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Bending ☐ Laying Down

☐ Other: _____

Have you had chiropractic care before? ☐ No ☐ Yes ☐ Describe: _____

Do you take: ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin ☐ Birth control ☐ OTC Medications ☐ Other (List at bottom)

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental Exam _____ MRI/CT/Other _____

Sleep _____ hrs/night Position: ☐ Back ☐ Side ☐ Stomach ☐ Changes: _____

Age of mattress: _____ Bed comfortable? ☐ Yes ☐ No Describe Pillow: _____

Non job exercise _____days/wk _____ hrs/day What type of exercise: _____

Do you wear? ☐ Bracing ☐ Foot Support Describe: _____

Conditions: Check conditions you have or have had in the past

☐ AIDS	☐ Diabetes	☐ Liver Disease	☐ Rheumatic Fever
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Scarlet Fever
☐ Anemia	☐ Epilepsy	☐ Migraine Headaches	☐ Stroke
☐ Anorexia	☐ Fractures	☐ Miscarriage	☐ Suicide Attempt
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Thyroid Problems
☐ Arthritis	☐ Goiter	☐ Multiple Sclerosis	☐ Tonsillitis
☐ Asthma	☐ Gonorrhea	☐ Mumps	☐ Tuberculosis
☐ Bleeding Disorders	☐ Gout	☐ Osteoporosis	☐ Tumors/Growths
☐ Breast Lump	☐ Heart Disease	☐ Pacemaker	☐ Typhoid Fever
☐ Bronchitis	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Polio	☐ Vaginal Infections
☐ Cancer	☐ Herpes	☐ Prostate issue	☐ Venereal Disease
☐ Cataracts	☐ High Cholesterol	☐ Prosthesis	☐ Whooping cough
☐ Chemical Dependency	☐ HIV Positive	☐ Psychiatric Care	☐ Other: _____
☐ Chicken Pox	☐ Kidney Disease	☐ Rheumatoid arthritis	_____

MEDICATIONS: List medications you are currently taking	**VITAMINS/HERBS/MINERALS/SUPPLEMENTS**
ALLERGIES:	

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

GENERAL
- ☐ Bruise Easily
- ☐ Chills
- ☐ Chronic Fatigue
- ☐ Dental Problems
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weight Gain

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

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

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ 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
- ☐ Acne
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

MEN ONLY
- ☐ Breast Lump
- ☐ Erection difficulties
- ☐ Lump in testicle(s)
- ☐ 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: _____
Mammogram?: _____
Are you pregnant? _____
Number of children: _____

NECK, BACK, EXTREMITIES Check symptoms you currently have or had in the past year:

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
- 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

MID-BACK
- ☐ Mid back pain
- ☐ Mid back stiffness
- ☐ Pain between shoulder blades
- ☐ 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
☐ Tingling in arm	☐ R	☐ L
☐ Tingling in fingers	☐ R	☐ L
☐ Numbness in arm	☐ R	☐ L
☐ Numbness in fingers	☐ R	☐ L
☐ Weakness of arm	☐ R	☐ L
☐ Weakness of hand	☐ R	☐ L

- ☐ Hands cold
- ☐ Hands burning
- ☐ Discoloration of hands

LOW BACK
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Muscle spasms in low back
- ☐ Low back feels out of place

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 knee	☐ R	☐ L
☐ Leg cramps	☐ R	☐ L

- ☐ Difficulty walking
- ☐ Difficulty balancing on foot
- ☐ Muscle spasms in leg

OTHER SYMPTOMS:
_____
_____
_____
_____
_____
_____
_____
_____

I certify that 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 Doctor: _____ Date: _____