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
☐ Ostiopath ☐ 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 _____

Have you ever had chiropractic care for other problems? ☐No ☐Yes ☐When? _____

Do you take ☐Muscle relaxers ☐Pain killers ☐Insulin ☐Birth control pills ☐Over-the-counter medication

☐Other prescription drugs _____ Please list all medication in the space at the bottom of the page

Date of last: Physical exam _____ Spinal x-ray _____ Blood test _____

Spinal exam _____ Chest x-ray _____ Urine test _____

Dental x-ray _____ MRI, CT-bone scan, bone scan _____

Sleep _____ hrs/night Do you sleep on your ☐Back ☐Side ☐Stomach Non-job exercise _____ hrs/week

Age of mattress _____ or waterbed _____ Is your bed comfortable? ☐No ☐Yes

What kind of pillow do you use? ☐Thick ☐Medium ☐thin ☐None ☐Support

Do you wear ☐Heel lifts ☐Shoe lifts ☐Arch supports ☐Orthotics, 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 problem	☐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**
Allergies _____	
Pharmacy Name _____ Phone _____	

General Symptoms - Check symptoms you currently have or have had in the past year

General
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

Genito-urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ 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 heart beat
- ☐ Low blood pressure
- ☐ 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
- ☐ Sore that won't heal

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 menstrual period _____

Date of last pap smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children? _____

Neck, Back, Extremities - Check symptoms you currently have or have 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 (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
- ☐ 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 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 ☐R ☐L

Low back
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ 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 knee ☐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 _____ _____

Doctor Date