

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

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 exercise? Yes No Hours per week _____ What activity(s)? _____

Are you dieting? Yes No Since: _____ Do you smoke? Yes No _____ packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? Yes No _____ drinks per day.

Do you wear? Heal lifts Arch supports Prescription Orthotics

For women: Are you pregnant or nursing? Yes No If pregnant, How many weeks? _____

Date of last menstrual period: _____

Medical History

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

Are you here because of an accident? _____ What type? _____

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? _____

History of Treatment

Primary care physician: _____ Phone: _____

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

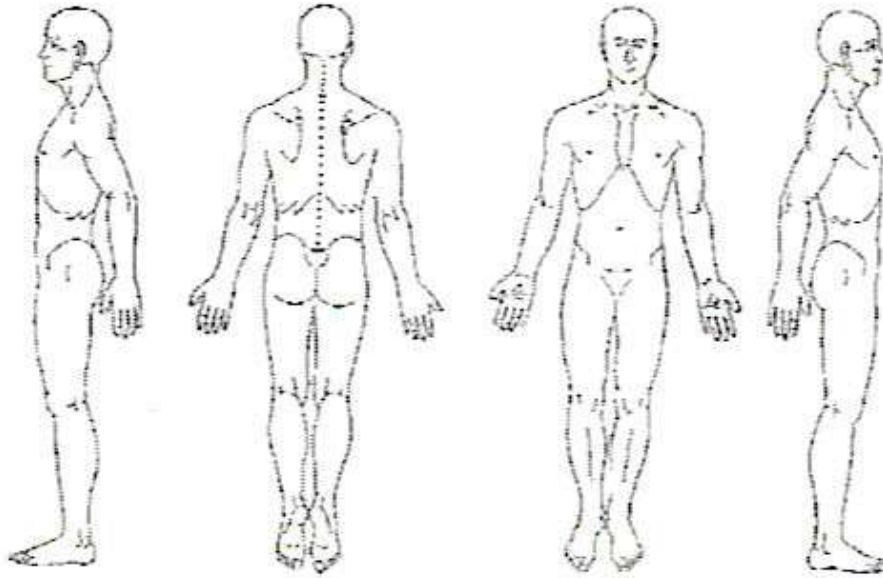
Have you seen a chiropractor before? ___Yes ___ No Who referred you to us? _____

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

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left

Back

Front

Right

On a scale of one to ten how intense are your symptoms? Not intense ①②③④⑤⑥⑦⑧⑨⑩ Unbearable

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

Additional comments you would like the doctor to know: _____

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