DATE: ______________________

PATIENT HEALTH QUESTIONNAIRE

Please complete the following questionnaire. Your answers will help us to determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily we will not accept your case.

THANK YOU

NAME: ______________________ **PHONE:** (P)______________________

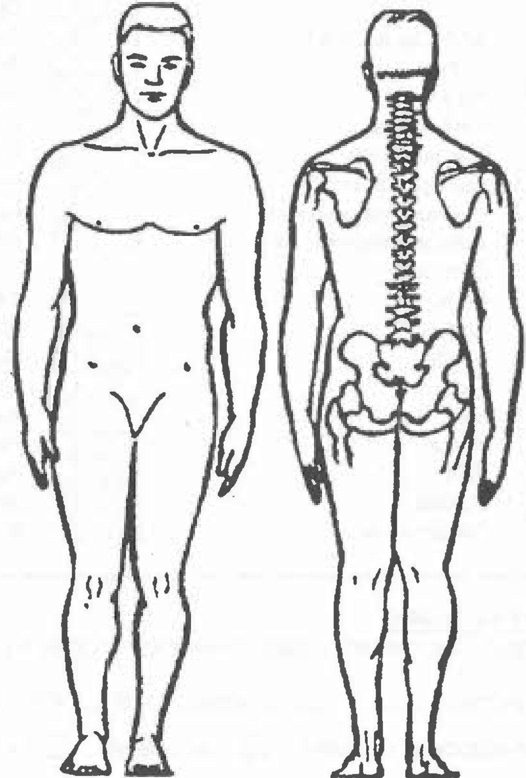
ADDRESS: ______________________ (B)______________________

CITY: ______________ **STATE:** _____ **POSTCODE:** __________ (M)______________________

DATE OF BIRTH: ______________ **EMAIL:** ______________________

OCCUPATION: ______________________

AREAS OF SYMPTOMS
Indicate by marking areas



REFERRED BY: ☐ Other
☐ Patient ______________ ☐ Doctor ______________

REASON FOR THIS VISIT: (Describe major complaints and symptoms) ______________________

IS THE REASON FOR YOUR VISIT TO:
- ☐ Alleviate your symptoms
- ☐ Correct the cause of your symptoms

WHEN DID YOU FIRST NOTICE THESE SYMPTOMS?
____

WHOM HAVE YOU CONSULTED FOR THIS PROBLEM?
____

DID THE DOCTOR TAKE:
☐ X-Ray ☐ C/T Scan ☐ MRI ☐ Ultra Sound

WHAT TREATMENT HAVE YOU RECEIVED?
____

HAS THIS HAPPENED BEFORE? ☐ Yes ☐ No
If Yes, When? ______________________

HAVE YOU HAD CHIROPRACTIC CARE BEFORE?
Where: ______________________
When: ______________________

DATE OF LAST PHYSICAL EXAMINATION: ______________________

DRUGS YOU NOW TAKE:
☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers
☐ Tranquilizers ☐ Anti Inflamatories
☐ Insulin ☐ Other Names of medications: ______________________

HAVE YOU BEEN IN A ROAD ACCIDENT?
☐ Car ☐ Truck ☐ Motor Bike ☐ Bicycle ☐ As a Pedestrian When: ______________________

HAVE YOU HAD ANY OTHER PERSONAL INJURY OR ACCIDENT: When: ______________________

HAVE YOU EVER:

	YES	NO	
Been knocked unconscious	☐	☐	______
Been treated for a spinal or nerve disorder	☐	☐	______
Had a fractured bone	☐	☐	______
Been hospitalised other than for surgery	☐	☐	______
Had surgery	☐	☐	______

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE SUFFERED FROM:

☐ Alcoholism	☐ Diabetes	☐ Heart Disease	☐ Polio	☐ Cancer
☐ Anaemia	☐ Eczema	☐ Miscarriage	☐ Rheumatic Fever	☐ Goiter
☐ Arthritis	☐ Emphysema	☐ Measles	☐ Stroke	☐ Pleurisy
☐ Asthma	☐ Epilepsy	☐ Mumps	☐ Tuberculosis	☐ Ulcers

HAVE ANY MEMBERS OF YOUR FAMILY I.E. PARENTS/GRANDPARENTS SUFFERED FROM THE FOLLOWING:

☐ Diabetes	☐ Heart Problems	☐ Circulatory Problems
☐ Cancer	☐ Lung Problems	☐ Arthritis

Please check the appropriate box for any of the following symptoms which you now have or have had previously.
We want all the facts about your health before we accept your case.
THIS IS A CONFIDENTIAL HEALTH REPORT.

NEVER | OCCASIONAL | FREQUENT

GENERAL
- ☐☐☐ Allergy
- ☐☐☐ Convulsions
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Headache
- ☐☐☐ Neuralgia
- ☐☐☐ Numbness

MUSCLE & JOINT
- ☐☐☐ Arthritis
- ☐☐☐ Bursitis
- ☐☐☐ Foot trouble
- ☐☐☐ Low back pain
- ☐☐☐ Neck pain or stiffness
- ☐☐☐ Pain between shoulders

Pain or numbness in:
- ☐☐☐ Shoulders
- ☐☐☐ Arms
- ☐☐☐ Elbows
- ☐☐☐ Hands
- ☐☐☐ Hips
- ☐☐☐ Legs
- ☐☐☐ Knees
- ☐☐☐ Feet
- ☐☐☐ Sciatica
- ☐☐☐ Swollen joints

GASTRO-INTESTINAL
- ☐☐☐ Colon trouble
- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Difficult digestion
- ☐☐☐ Distension of abdomen
- ☐☐☐ Gall bladder trouble
- ☐☐☐ Hemorrhoids
- ☐☐☐ Liver trouble
- ☐☐☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐☐☐ Asthma
- ☐☐☐ Colds
- ☐☐☐ Deafness
- ☐☐☐ Earache
- ☐☐☐ Ear discharge
- ☐☐☐ Ear noises
- ☐☐☐ Eye pain
- ☐☐☐ Nasal obstruction
- ☐☐☐ Nosebleeds
- ☐☐☐ Sinus infection

CARDIO-VASCULAR
- ☐☐☐ Hardening of arteries
- ☐☐☐ High blood pressure
- ☐☐☐ Low blood pressure
- ☐☐☐ Pain over heart
- ☐☐☐ Poor circulation
- ☐☐☐ Rapid heart beat
- ☐☐☐ Slow heart beat
- ☐☐☐ Swelling of ankles

RESPIRATORY
- ☐☐☐ Chest pain
- ☐☐☐ Chronic cough
- ☐☐☐ Difficult breathing
- ☐☐☐ Spitting up blood
- ☐☐☐ Spitting up phlegm
- ☐☐☐ Wheezing

SKIN
- ☐☐☐ Bruise easily
- ☐☐☐ Dryness
- ☐☐☐ Skin eruptions (rash)
- ☐☐☐ Varicose veins

GENITO-URINARY
- ☐☐☐ Bed-wetting
- ☐☐☐ Blood in urine
- ☐☐☐ Frequent urination
- ☐☐☐ Inability to control kidneys
- ☐☐☐ Kidney infection or stones
- ☐☐☐ Painful urination
- ☐☐☐ Prostate trouble
- ☐☐☐ Pus in urine

FOR WOMEN ONLY
- ☐☐☐ Congested breasts
- ☐☐☐ Cramps or backache
- ☐☐☐ Excessive menstrual flow
- ☐☐☐ Hot flushes
- ☐☐☐ Irregular cycle
- ☐☐☐ Lumps in breast
- ☐☐☐ Menopausal symptoms
- ☐☐☐ Painful menstruation

ACCIDENTAL INJURY

IF YOURS IS A MOTOR ACCIDENT OR WORKER'S COMPENSATION INJURY, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Date of Accident: ______________ Hour: ____ AM ____ PM Location: ______________________________

HOW DID ACCIDENT OCCUR? ☐ Auto collision ☐ On the job injury ☐ Other

IF NOT AN AUTO COLLISION, PLEASE DESCRIBE THE CIRCUMSTANCES: ______________________________

____

____

DID YOU REPORT THE INJURY TO: ☐ Foreman ☐ Employer ☐ Police ☐ Yes ☐ No

DID HE / THEY RECOMMEND CARE AT OUR OFFICE? ☐ Yes ☐ No

HAVE YOU FILLED OUT A TAC OR WORKCARE FORM? ☐ Yes ☐ No

HAVE THE FORMS BEEN LODGED? ☐ Yes ☐ No

IF AUTO COLLISION WERE YOU: ☐ Driver ☐ Passenger ☐ Pedestrian

IF AUTO COLLISION WERE YOU: ☐ Struck from behind ☐ Right side ☐ Left side ☐ Front ☐ Auto was parked

DID YOUR CAR STRIKE THE OTHER(S) INVOLVED? ☐ Yes ☐ No

OR DID THE OTHER CAR STRIKE YOURS? ☐ Yes ☐ No ☐ Undetermined

LIST THE EXTENT OF THE INJURIES AS YOU KNOW THEM: ______________________________

____

____

DID YOU REQUIRE POST ACCIDENT HOSPITALIZATION: ☐ Yes ☐ No

HAVE YOU LOST ANY DAYS OF WORK? ☐ Yes ☐ No Dates: ______________________________

____

SIGNATURE: ______________________________ DATE: ______________________________