Glen Burnie

Chiropractic & Physical Therapy, LLC

HEALTH QUESTIONNAIRE

DR: ____________________

PATIENT NAME: ____________________ DATE: __________ PATIENT NO: __________ DOB: __________

REFERRED BY: ____________________ PATIENT OCCUPATION: ____________________

DATE OF LAST MENSTRUAL PERIOD: ____________________ PREGNANT: ____ YES ____ NO

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? ____ YES ____ NO

AGE OF MATRESS __________ ____ COMFORTABLE ____ UNCOMFORTABLE

HAVE YOU BEEN IN AN AUTO ACCIDENT? ____ PAST YEAR ____ PAST 5 YEARS ____ OVER 5 YEARS ____ NEVER

DESCRIBE: ____________________

MAJOR COMPLAINTS

WHAT IS YOUR MAJOR COMPLAINT? ____________________ __________

HOW LONG HAVE YOU HAD THIS CONDITION? __________ HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST? __________

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ____ YES ____ NO

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? ____ COUGHING ____ SNEEZING ____ NECK MOVEMENT

____ REACHING ____ LIFTING ____ BENDING ____ SITTING ____ STANDING

____ WALKING ____ SLEEPING ____ KNEELING ____ CLIMBING ____ GETTING OUT OF CAR

SYMPTOMS ARE BETTER IN ____ AM ____ MIDDAY ____ PM

SYMPTOMS ARE WORSY IN ____ AM ____ MIDDAY ____ PM

OTHER DOCTORS WHO HAVE TREATED THIS CONDITION: ____________________ __________

DRUGS YOU NOW TAKE: ____ ANTI-INFLAMMATORY (Aspirin, Motrin, Etc) ____ MUSCLE RELAXANT ____ PAIN MEDICATIONS/ANALGESIC

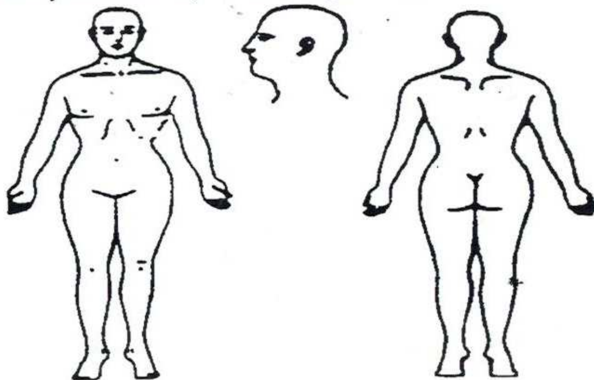
____ INSULIN ____ TANQUILIZERS ____ BIRTH CONTROLS PILLS ____ BLOOD PRESSURE ____ OTHERS: __________

LIST SURGICAL OPERATIONS AND YEARS: ____________________

NAME OF FAMILY PHYSICIAN: ____________________ DATE OF LAST PHYSICAL EXAMINATION: __________

PAIN DIAGRAMS

Please mark your areas of pain on the figures below:



MEDICAL HISTORY

____ NO PREVIOUS CONDITIONS/ILLNESS

____ DIZZINESS
____ NECK PAIN
____ BACK ACHES
____ HEADACHES
____ NEURITIS
____ DIGESTIVE DISORDER
____ NERVOUSNEES
____ ARTHRITIS
____ ASTHMA
____ SINUS TROUBLE
____ HAY FEVER
____ ALLERGIES

____ TYROID PROBLEM
____ HIGH BLOOD PRESSURE
____ LOW BLOOD PRESSURE
____ HEART TROUBLE
____ HIV/ARC
____ SEXUALLY TRANSMITTED DIS
____ ULCER
____ CANCER POLIO
____ RHEUMATIC FEVER
____ SERIOUS INJURY
____ BONE FRACTURE

____ SPINAL DISC DISEASE
____ MULTIPLE SCLEROSIS
____ SCOLIOSIS
____ MENTAL/EMOTIONAL DIFF
____ PROSTATE TROUBLE
____ KIDNEY TROUBLE
____ OTHER

____
____
____

REVIEW OF SYSTEMS:

1. Are you presently suffering (or withing the past six months suffered) from any of the following?:

a. GENERAL

____ Normal ____ Chilis
____ Fatigue ____ Weight Change
____ Weakness ____ Night Sweats
____ Fever ____ Other

b. SKIN

____ Normal ____ Eczema
____ Rash ____ Hair Changes
____ Redness ____ Nail Changes
____ Itching ____ Other

c. NEUROLOGIC

____ Normal ____ Fainting
____ Headache ____ Convulsions
____ Dizziness ____ Other

d. EYES

	Left	*Right*
Normal	____	____
Vision Trouble	____	____
Pain	____	____
Discharge	____	____
Other	____	____

e. EARS

	Left	*Right*
Normal	____	____
Hearing Trouble	____	____
Ringing	____	____
Pain	____	____
Discharge	____	____
Other	____	____

f. NOSE

____ Normal ____ Absense of Smell
____ Pains ____ Other
____ Bleeding

g. MOUTH/THROAT

____ Normal ____ Absence of Taste
____ Sores ____ Abnormal Taste
____ Bleeding ____ Other

h. CARDIO-VASCULAR PULMONARY

____ Normal ____ Blue Extremities
____ Cough ____ Murmur
____ Wheezing ____ Chest Pain
____ Diff Breating ____ Palpitations

i. BREASTS

____ Normal ____ Dimpling
____ Lumps in Brst ____ Discharge
____ Pain ____ Other
____ Redness/Itching

j. GASTROINTESTINAL

____ Normal ____ Vomiting
____ Decr Appetite ____ Diarrhea
____ Incr Appetite ____ Constipation
____ Abdominal Pain ____ Other

k. GENITOURINARY

____ NORMAL
____ Impotence
____ Sterility
____ Inability to hold Uringe
____ Painful Urination
____ Frequent Urination
____ Irregular Mnestruation
____ Painful Menstruation
____ Abnormal Vaginal Bleeding
____ Other

i. ENDOCRINE

____ Normal ____ Goiter
____ Heat/Cold Intoler ____ Mood Swing
____ Sugar in Urine ____ Other

m. PSYCHOLOGIC

____ Normal ____ Phobias
____ Anxiety ____ Mood Swings
____ Depression ____ Other
____ Memory Loss or Impairment

2. What are our habits?

	Never	Ocassionally	Moderately	Excessively
Smoking	____	____	____	____
Alcohol	____	____	____	____
Recreational Drugs	____	____	____	____
Exercise	____	____	____	____

3. Family History?

Father	Mother	Brothers	Sisters	Children	
____	____	____	____	____	Cancer
____	____	____	____	____	Diabetes
____	____	____	____	____	Heart Trouble
____	____	____	____	____	Hight Blood Pressure
____	____	____	____	____	Stroke
____	____	____	____	____	Multiple Sclorosis
____	____	____	____	____	Headaches
____	____	____	____	____	Neck Problems
____	____	____	____	____	Back Problems
____	____	____	____	____	Disc Problems
____	____	____	____	____	Joint Problems
____	____	____	____	____	Arthritis
____	____	____	____	____	Pinched Nerves
____	____	____	____	____	Osteoporosis
____	____	____	____	____	Scoliosis
____	____	____	____	____	Bad Posture

PATIENT SIGNATURE: ________________________

DATE: ____________________