Health Questionnaire

The nervous system controls and coordinates all cells, organs and tissues of the body.

Below are some of the symptoms related to nerve interference, chiropractors call this SUBLUXATION

Please check the boxes that apply

Cervical Region

Past	Present		Past	Present		Past	Present	
☐	☐	Neck Pain	☐	☐	Fatigue	☐	☐	Swollen Tonsils/Adenoids
☐	☐	Migraines	☐	☐	Thyroid Disease	☐	☐	Tachycardia
☐	☐	Headaches	☐	☐	Sinus Infection	☐	☐	Atrial Fibrillation
☐	☐	Shoulder Pain	☐	☐	Balance/Coordination	☐	☐	Arthritis
☐	☐	Arm Pain	☐	☐	Epilepsy/Seizure	☐	☐	Cervical Stenosis
☐	☐	Radiating Arm/Hand	☐	☐	ADD/ADHD	☐	☐	Carpal Tunnel
☐	☐	Eyes/Vision Problems	☐	☐	High Blood Pressure	☐	☐	Toe Walker
☐	☐	Ear Aches/Infections	☐	☐	Difficult Sleep	☐	☐	Other
☐	☐	Vertigo/Dizzy	☐	☐	Reoccurring Sore Throat			

Thoracic Region

Past	Present		Past	Present		Past	Present	
☐	☐	Mid Back Pain	☐	☐	Nausea/Vomiting	☐	☐	DISH
☐	☐	Rib Pain	☐	☐	Gout	☐	☐	Liver Disease
☐	☐	Chest Pain	☐	☐	Kidney Disease	☐	☐	Diabetes
☐	☐	Scapular Pain	☐	☐	Gallstones	☐	☐	Hiatal Hernia
☐	☐	Acid Reflux/GERD	☐	☐	Allergies	☐	☐	Other
☐	☐	Stomach Ache	☐	☐	Adrenal Fatigue			
☐	☐	Chronic Cough	☐	☐	Skin Conditions/Rash			
☐	☐	Reoccurring Bronchitis	☐	☐	Fibromyalgia			
☐	☐	Heart Conditions	☐	☐	Athritis			

Lumbar/Sacroiliac Region

Past	Present		Past	Present		Past	Present	
☐	☐	Low Back Pain	☐	☐	Bedwetting	☐	☐	Gas/Bloating
☐	☐	Hip Pain	☐	☐	Incontinence	☐	☐	Infertility
☐	☐	Sacroiliac (SI) Pain	☐	☐	Ankle Pain	☐	☐	PMS
☐	☐	Sciatic (Back of leg) Pain	☐	☐	Foot Pain	☐	☐	Prostate Problems
☐	☐	Lateral (Side) of Leg Pain	☐	☐	Plantar Fascitis	☐	☐	Urinary/Bladder Problems
☐	☐	Anterior (Front) of Leg Pain	☐	☐	Knee Pain	☐	☐	Miscarriage
☐	☐	Sacral (tailbone) Pain	☐	☐	Constipation	☐	☐	Impotence
☐	☐	Coccyx Pain	☐	☐	Diarrhea	☐	☐	Stenosis
☐	☐	Leg Weakness	☐	☐	Crohn's Disease	☐	☐	Other

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PATIENT INFORMATION

Name:_____ Date:_____ Height:_____ Weight:_____

Address:_____ City:_____ State:_____ Zip:_____

Circle one: Female - Male ☐ Single ☐ Married

Home Phone:_____ Cell:_____ Work:_____

E-mail Address:_____ Driver's License#: _____

Date of Birth:_____ Age:_____ Occupation: (retired? past employment)_____

WHO MAY WE THANK FOR REFERRING YOU? _____

CONTACT IN CASE OF EMERGENCY: Name_____ Phone#_____

CURRENT PRIMARY COMPLAINTS

(Circle) Pain Free 1 - 10 Worst

1: _____ 1 2 3 4 5 6 7 8 9 10

2: _____ 1 2 3 4 5 6 7 8 9 10

3: _____ 1 2 3 4 5 6 7 8 9 10

What do you think caused your symptoms (past traumas,falls,sports injuries)?_____

Family Physician:_____ **Date of Last Physical:**_____

List Surgeries: (with dates):

1:_____ 3:_____

2:_____ 4:_____

List Medication: Name / Purpose:

1:_____ 4._____

2:_____ 5._____

3:_____ 6._____

Have you been diagnosed with: (circle)

Diabetes – Heart Disease – Stroke – Cancer – Autoimmune Disease – MRSA – Hepatitis – Sexually Transmitted Disease

Do you experience pain daily? ☐Y ☐N Is It Getting Worse ☐Y ☐N

Does your pain wake you at night? ☐ Y ☐ N

Pain is worse when I? (circle) Sit - Rise from Sitting - Walk - Bend - Reach above Shoulders - Run - Play Sports - Push – Pull – Lift

What makes it better?_____ Other Treatment? ☐ M.D. ☐ PT. ☐ D.C. ☐ Rx Other _____

History of any sports injuries, concussion, emergency room visits, auto accidents, etc. Please explain: _____

_____

_____

Family Health History: Spinal Defects/Heart Disease/Stroke/Diabetes/Cancer/Other? _____

CHIROPRACTIC LIFESTYLE

Describe the reason for your visit: _____

Have you been adjusted by a chiropractor before? ☐ Y ☐ N For What? _____

Doctor's Name: _____ Date of Last Visit? _____

How long has it been since you felt your best? _____

Does pain interfere with (circle): Work / Sleep / Daily Routine / Sports / Family Times / Other

Smoking Status: Everyday/ Occasional / Former/ Never Alcohol Status: Everyday / Occasional / Never What % of your diet is vegetables?_____

Do you exercise regularly? ☐ Y ☐ N What type of exercise?: _____

How old is your mattress? _____ What type of pillow do you use? _____

Do you sleep on your? (circle) Side – Back – Stomach – All

Are you Pregnant? ☐Y ☐N

CHIROPRACTIC LIFESTYLE, continued

Do you take any vitamins/supplements? ☐ Y ☐ N If yes, please list with brand name: _____

Are you interested in taking an active role in your recovery? ☐ Y ☐ N

WERE YOU AWARE THAT:

Doctors of Chiropractic work with the Nerve System? ☐ Y ☐ N

The Nerve System controls all bodily functions and systems? ☐ Y ☐ N

Chiropractic is the largest natural healing profession in the world? ☐ Y ☐ N

GOALS FOR YOUR CARE

☐ Relief Care: Symptomatic relief of pain or discomfort

☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptom.

☐ Comprehensive Care: Bring whatever is NOT Working in the body to the highest state of health possible with Chiropractic care.

☐ The Doctor should select the type of care appropriate for my condition.

MOST SPINAL CONDITIONS BEGIN IN CHILDHOOD

Number of Children: _____ Ages: _____

Have they been check by a chiropractor? ☐ Y ☐ N If yes, Doctor's name: _____ Date of Last Visit? _____

Have they had any sports injuries/accidents/falls/ER visits/significant traumas etc. ☐ Y ☐ N If yes please describe: _____

_____

Would you like to have them checked? ☐ Y ☐ N

DRAW YOUR SYMPTOMS

Please draw and describe ANY and ALL symptoms. While some seem unrelated to the purpose of today's visit, it may be important for an accurate diagnosis.

USE THE KEY:
SHARP = **S**
SPASM = **SP**
NUMBNESS/TINGLING = **NT**
BURNING = **B**
RADIATING = **R**
ACHING = **A**