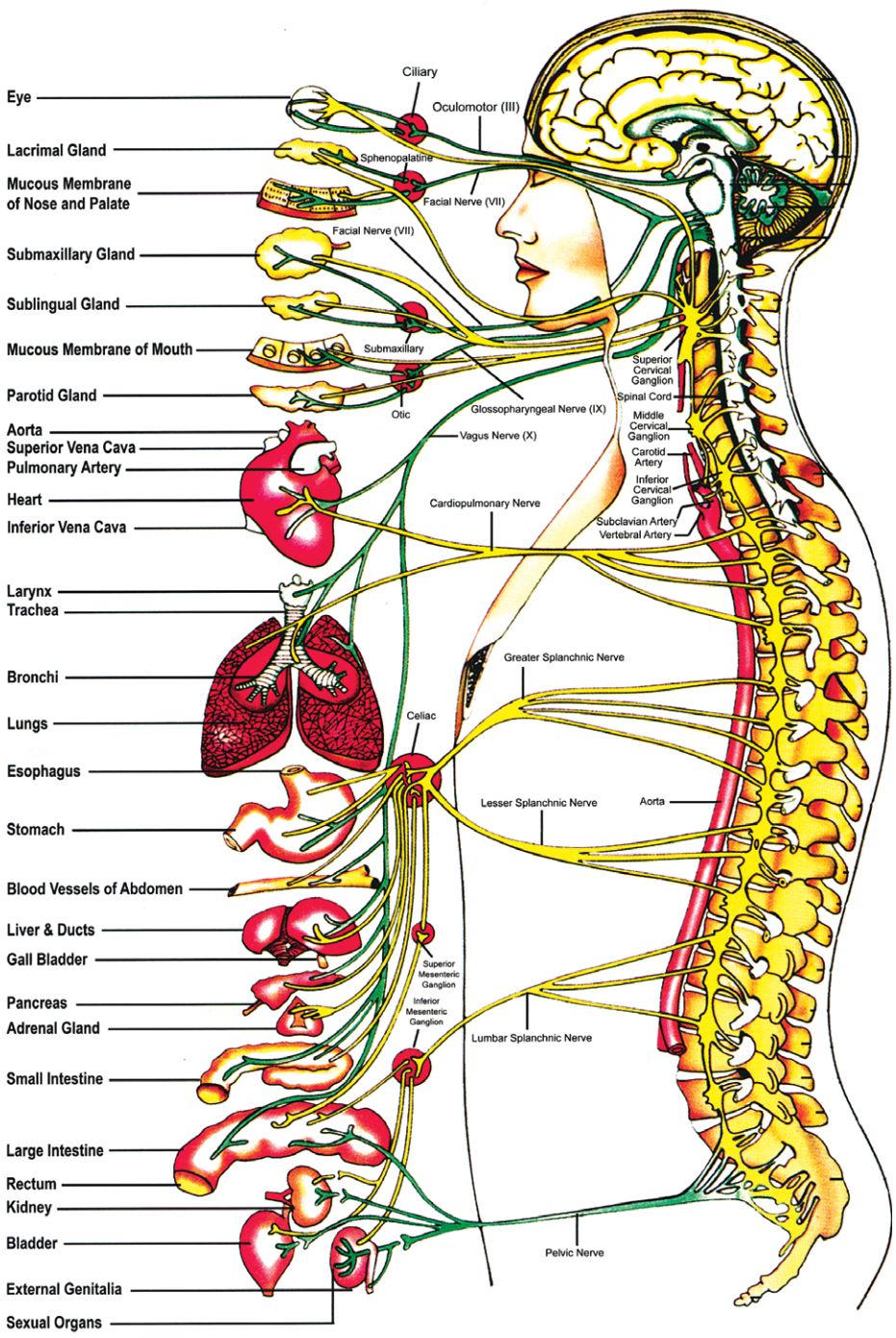
CHIROPRACTIC
HEALTH QUESTIONNAIRE



Past	Present	
		Eye or Sinus
		Ear Infections or Hearing Disorders
		High Blood Pressure or Heart Beat Irregularity
		Loss of Taste or Smell
		Headaches or Migraines
		Thyroid Disorders or Fatigue
		Nervousness or Anxiety
		Insomnia or Sleep Disorders
		Dizziness or Vertigo
		Neck or Shoulder Pain
		Mid Back Pain
		Radiating Arm/Hand Pain or Numbness
		Reoccurring Sore Throats or Chronic Cough
		Asthma or Difficulty Breathing
		Arthritis
		Stomach Discomfort or Acid Reflux
		Digestive Disorders or Irritable Bowel
		Nausea or Vomiting
		Gout and/or Kidney Disorders
		Gall Bladder Problems
		Allergies or Adrenal Problems
		Constipation or Diarrhea
		Abdominal Pain
		Low Back Pain
		Hemorrhoids
		Urinary Disorders/Bladder/Prostate
		Menstrual Disorders and/or PMS
		Numbness or Pain in Legs/Thighs/Sciatica
		Miscarriages and/or Infertility

SYMPTOMS RELATED TO NERVE INTERFERENCE - SUBLUXATION

Chiropractors deal with the relationship between your spine and nerve system. The nerve system controls and coordinates ALL cells, organs and tissues of the body. A spinal subluxation can cause a wide variety of health complaints and have 3 components.

- Misalignment: Similar to crooked teeth. Spinal misalignments will cause wear and tear (arthritis) and are visualized by a standing x-ray.
- Joint Fixation: Lack of mobility or too much mobility will lead to spinal decay (arthritis).
- Nerve Pressure: Similar to a plugged water valve in an irrigation system. With less water to the plant, it slowly gets sick and dies.

PATIENT INFORMATION

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

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

Circle one: Female - Male ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of Children: _____

Home Phone: _____ Cell: _____ Work: _____

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

Date of Birth: _____ Age: _____ SSN: _____

Occupation: (retired? past employment) _____ Job Title: _____

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: _____ 2: _____

3: _____ 4: _____ .

List Medication: Name / Dosage (ie: 13mg. 1x/day) Include over the counter:

1: _____

2: _____

3: _____

Have you been diagnosed with: (circle)

Diabetes - Heart disease - Stroke - Cancer - Autoimmune disease - MRSA - HIV/AIDS - Hepatitis - Fibromyalgia - Chronic Fatigue - Arthritis - Sexually transmitted disease

Medication Allergies? Name _____ Reaction _____ Comes and goes ☐ Y ☐ N

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 - Climb - Run - Play Sports - Push – Pull – Lift

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

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

CHIROPRACTIC LIFESTYLE

Describe the reason for this visit: _____

What is important to you in a Doctor-Patient relationship? _____

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

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

Have your children been checked by a Chiropractor? ☐ Y ☐ N **Are you pregnant?** ☐ Y ☐ N

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

Does pain interfere with: Work / Sleep / Daily Routine / Sports / Family Time / Other

Smoking Status: Everyday / Occasional / Former / Never **Alcohol Status:** Everyday / Occasional / Never

Do you exercise regularly? ☐ Y ☐ N / What % of Diet is Vegetables? _____

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

CHIROPRACTIC LIFESTYLE, continued

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

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

IN COMPLIANCE WITH GOVERNMENT HEALTH REQUIREMENTS

Preferred Language: _____ Ethnicity: Hispanic or Latino / Neither / Decline Answer

Race: American Indian or Alaskan Native / Asian / Black or African American / Caucasian / Hawaiian or Pacific Islander / Other / Decline

☐ I choose to decline receipt of my clinical summary after every visit. (These are often blank as a result of the nature and frequency of chiropractic care).

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.

DRAW YOUR SYMPTOMS

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

USE THE KEY:

SHARP = **S**
DULL = **D**
SPASM = **S**
THROBBING = **T**
CRAMPING = **C**
NUMBNESS = **N**
TINGLING = (T)
ELECTRICAL = **E**
WEAKNESS = **W**
BURNING = **B**
ACHING = **A**
STIFF = ◯
RADIATING = ——