LAUREL CHIROPRACTIC AND REHAB
CONFIDENTIAL HEALTH QUESTIONNAIRE

Let us extend a warm and personal welcome to you on behalf of the Doctors and Staff. Our goal is to provide you with the finest healthcare possible. Your attitude about your health is as important to us as the specific reason you have consulted our office. Please mark the one box that **most closely** reflects your personal values.

☐ **Symptomatic Treatment Only** I only consult a Health Provider when I have an ache, pain, or symptom and I generally do not try to prevent problems from occurring.

☐ **Prevention / Wellness** I occasionally consult a Health Provider for treatment of symptoms but my primary focus is on being healthy so symptoms do not occur.

Patient Name: _____Today's Date:_____

Describe your **Primary Complaint:**_____

_____

On a scale of 0-10, circle your current level of pain: **0** = no pain, **10** = severe pain 0 1 2 3 4 5 6 7 8 9 10

Is this problem the result of a: ☐ Work Injury ☐Motor Vehicle Accident ☐ Other _____

Have you been treated for this complaint before?: ☐ No ☐Yes If yes, by ☐ M.D. ☐ D.O. ☐ Therapist (P.T.)

☐ Chiropractic Physician ☐Other_____ Their Name: _____

If yes, what did they do and/or recommend? _____

When did your symptoms appear? _____Is the condition getting worse? ☐Yes ☐ No ☐ Unknown

How often are your symptoms present? ☐Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily routine ☐Recreation ☐Other_____

Movements that are painful to perform: ☐ Sitting ☐ Walking ☐Bending ☐Lying ☐Other _____

Secondary Complaint :_____ Circle pain level 0 1 2 3 4 5 6 7 8 9 10

Other Complaint:_____ Circle pain level 0 1 2 3 4 5 6 7 8 9 10

Describe the activities of your occupation: (i.e., sitting, lifting)_____

Have you ever had chiropractic care for other problems: ☐ No ☐ Yes If yes, when? _____

List current **Medications** and **Vitamin Supplements** you are taking:

Product	**Reason for taking**	**List side effects**
1.		
2.		
3.		
4.		
5.		

Additional:_____

Pharmacy name: _____ Phone: _____ Allergic to: _____

Who is your Primary Care Physician?_____ Last Seen?_____

Date of last: Physical exam _____ Spinal Exam _____ Blood test _____ Urine test _____

Spinal X-ray _____ Chest X-ray _____ Dental X-ray _____ Other: MRI, CT scan, bone scan _____

How many hours do you sleep? _____ hours/night. Do you sleep on your: ☐ Back ☐Side ☐ Stomach

Is your bed comfortable? ☐ No ☐ Yes What is the age of your mattress _____ or waterbed _____?

What kind of pillow do you use? ☐Thick ☐ Medium ☐ Thin ☐ Cervical ☐ None ☐ Other _____

Do you wear? ☐ Heel lifts ☐ Shoe lifts ☐ Arch supports ☐ Orthotics, describe _____

How much exercise do you get? _____ hours/week. What kind of exercise? _____

Do you smoke? ☐ No ☐ Yes, If yes how much?_____day.

Do you drink alcohol? ☐ No ☐ Yes, If yes how much?_____ ☐ day ☐ Week ☐ Month

Do you drink caffeinated drinks?☐ No ☐ Yes. If yes, I drink _____cups/cans per day of_____

Do you have a permanent disability rating? ☐ No ☐ Yes, date received_____ Rating %_____

Do you have a service animal? ☐ No ☐ Yes, please provide supporting documentation for our records.

Do you have any **nutritional** concerns or questions regarding: ☐weight loss/gain ☐ fatigue ☐ muscle building

☐athletic performance ☐ osteoporosis ☐recurrent sprains/strains ☐Other_____

Past and Present Health History

Patient Name _____ Date _____

If you have ***ever*** had a listed symptom in the ***past***, please check that symptom in the ***Past Column***. If you are ***presently*** troubled by a particular symptom, check that symptom in the ***Present Column***.
KNOWLEDGE OF THESE SYMPTOMS MAY INFLUENCE THE TYPE OF TREATMENT YOU RECEIVE.

Past	Present	Condition
☐	☐	AIDS / HIV+
☐	☐	Abdominal Pain
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Ankle Pain ☐L ☐R
☐	☐	Angina
☐	☐	Anorexia/Bulimia
☐	☐	Anxiety
☐	☐	Appendicitis
☐	☐	Arm Pain ☐ L ☐ R
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Bladder Control Loss
☐	☐	Blood Disorder
☐	☐	Breast lump / sore
☐	☐	Cancer
Type:_____		
☐	☐	Chest Pain
☐	☐	Colitis
☐	☐	Constipation
☐	☐	Convulsions
☐	☐	Depression
☐	☐	Dermatitis/Rash
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Difficulty swallowing
☐	☐	Dizziness
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Excessive thirst
☐	☐	Fainting
☐	☐	Fever / Infection
☐	☐	Foot Pain ☐ L ☐ R
☐	☐	Frequent Urination
☐	☐	Fracture
☐	☐	Gall Bladder Disease
☐	☐	General Fatigue
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Hand Pain ☐ L ☐ R
☐	☐	**Headache**
☐	☐	Heart Attack
☐	☐	Heart Disease

Past	Present	Condition
☐	☐	Hepatitis
☐	☐	Hernia
☐	☐	Herpes-
☐	☐	Shingles / Cold Sores
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Hip Pain ☐ L ☐ R
☐	☐	Jaw pain/ TMJ
☐	☐	Kidney Disease
☐	☐	Knee Pain ☐ L ☐ R
☐	☐	Leg Pain ☐L ☐ R
☐	☐	Liver Disease
☐	☐	Loss of Appetite
☐	☐	**Low Back Pain**
☐	☐	Memory Loss
☐	☐	**Mid-Back Pain**
☐	☐	Migraines
☐	☐	Mononucleosis
☐	☐	Multiple Sclerosis
☐	☐	**Neck Pain**
☐	☐	Numbness
☐	☐	Osteoarthritis (OA)
☐	☐	Osteoporosis
☐	☐	Pacemaker
☐	☐	Painful Urination
☐	☐	Pneumonia
☐	☐	Polio
☐	☐	Prosthesis
☐	☐	Psychiatric care
☐	☐	Rapid Heart Beat
☐	☐	Rheumatic fever
☐	☐	Rheumatoid Arthritis
☐	☐	Sciatica
☐	☐	Scoliosis
☐	☐	Shoulder pain☐L☐R
☐	☐	Sinus problems
☐	☐	Stiffness of joint
☐	☐	Stroke / TIA
☐	☐	Suicide attempt
☐	☐	Swelling
☐	☐	Thyroid problems
☐	☐	Tingling sensation
☐	☐	Tinnitus (ear ringing)
☐	☐	Tonsillitis
☐	☐	Trouble sleeping
☐	☐	Tuberculosis
☐	☐	Tumors, growths

Past	Present	Condition
☐	☐	Typhoid fever
☐	☐	Ulcers
☐	☐	Venereal disease
☐	☐	Vertigo
☐	☐	Visual disturbances
☐	☐	Wrist pain ☐L ☐R
☐	☐	Other _____
_____		
_____		
Women Only:		
☐	☐	Abnormal Pap.
☐	☐	Breast Lump/Sore
☐	☐	Endometriosis
☐	☐	Irregular Period
☐	☐	Menopause Sympt.
☐	☐	Nipple Discharge
☐	☐	Painful Intercourse
☐	☐	P.M.S.
☐	☐	Vaginal Discharge
☐	☐	Vaginal Infection
☐	☐	Other_____
☐	☐	Birth Control Pills
☐	☐	Pregnancy
		# of Births_____
Men Only:		
☐	☐	Prostate Problems
☐	☐	Erection Difficulties
☐	☐	Penis Discharge
☐	☐	Lump on Testicles
☐	☐	Sore on Penis
☐	☐	Breast Lump
☐	☐	Other_____

Family History: If a family member has had any of the following, please mark the appropriate box.

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ Rheumatoid Arthritis
- ☐ Epilepsy
- ☐ Chronic Back Problems
- ☐ Chronic Headaches
- ☐ Stroke / TIA
- ☐ Other_____

I certify that this health information is complete and accurate to the best of my knowledge. I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient's Signature_____ Date:_____