Elan Wellness Service Corporation
2121 Ridge Ave, Suite 105, Aurora, IL 60504
Tel: (630) 499-9420 / Fax: (630) 499-9450

CONFIDENTIAL PATIENT QUESTIONNAIRE

Dear Patient: *Today's Date: _____/_____/_____*

In order for us to better help you, we need this important confidential questionnaire answered completely by you for your health care. *If you need any assistance, please do not hesitate to ask our staff for help. Please* write clearly for your health*! Thank you.*

Name______________________________ Prefer To Be Called____________________
Address______________________________ Home Phone__________________________
City__________________ State__________ Zip__________________ Work Phone__________________________
Sex ☐ M ☐ F Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced Age_____ Date of Birth_________________
Occupation __________________________ Employer____________________________ Years Employed________________________
Employer's Address________________________________ City__________ State_______ Phone________________________________
Spouse's Name________________________ Occupation____________________________ Number of Children____________________

Have you ever had ☐ Chiropractic ☐ Naturopathic care before? ☐ Yes ☐ No For what problem?__________________________________
What type of care / treatment are you seeking from this clinic? ☐ Chiropractic ☐ Naturopathic ☐ Physical Therapy ☐ Whatever Helps
You were referred to this clinic by ☐ Newspaper Ads ☐ Web ☐ Friend ☐ Clinic Sign ☐ Other____________________________________

What is your major complaint for which you came to our clinic?____
____
____
____
Other complaints____

Please describe in detail how your present illness developed / started from first sign and / or symptom to the present (includes time, place, reasons, courses, mode, results, etc.)
____
____
____
____
____

Are your symptoms the result of an auto accident, work- related injury or other personal injury(slip and fall, etc.)? If you answered yes, please fill out accident specific form, available at the front desk. ☐ Yes ☐ No

Did symptoms/pain begin ☐ gradually ☐ suddenly?

When was the very last episode of symptoms/discomforts experienced?____

How long have you had these episodes of symptoms?____

Please describe in detail how your health problem (s) disturbed / bothered you (including how each of the problems you described).
____
____
____
____
____

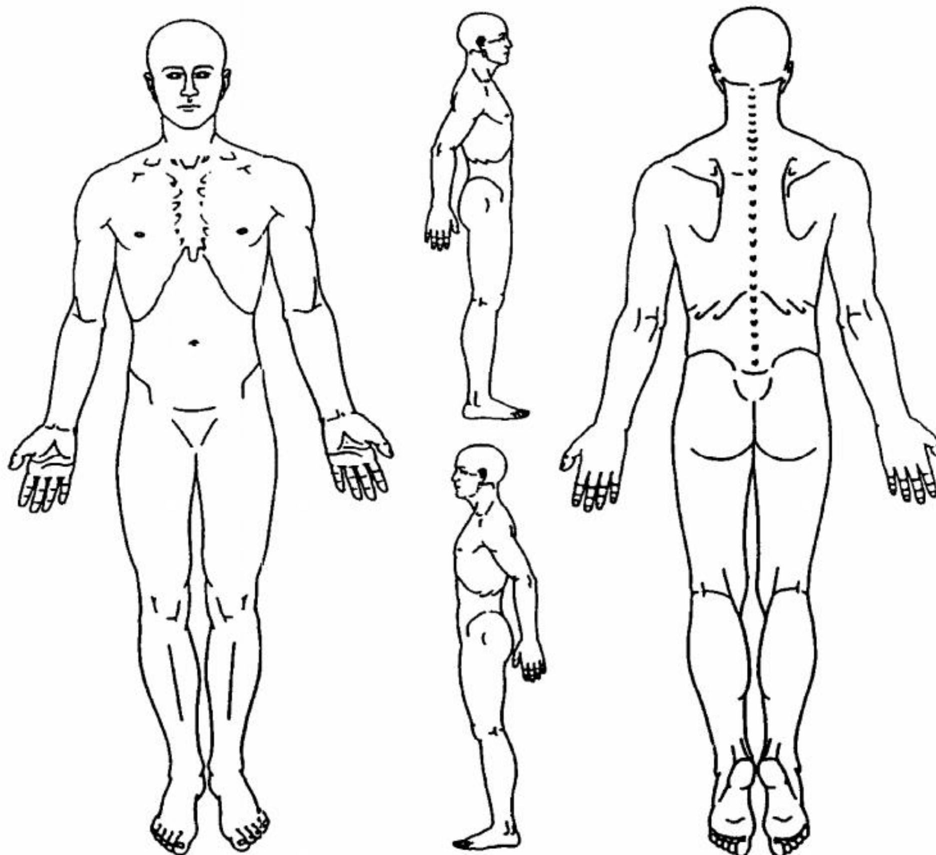
Are your symptom (s) / pain ☐ localized ☐ traveling? Please describe where your symptom (s) / pain go to____
____

Describe the quality / character of your symptom(s). Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc.

____
____
____

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache	> > > > > >	Numbness	= = = = = =	Pins and Needles	↓↓↓↓↓↓	Burning	× × × × × ×
Stabbing	∇ ∇ ∇ ∇ ∇	Throbbing	~ ~ ~ ~ ~ ~	Tingling	+ + + + +	Sharp	↔ ↔ ↔ ↔
Dull	0 0 0 0 0	Soreness	∩ ∩ ∩ ∩ ∩	Shooting	⊕ ⊕ ⊕ ⊕	Other	



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort, please circle.

What is your pain/discomfort like today? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
What is your least pain/discomfort? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
What is your worst pain/discomfort? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

How much time during an average day are you in pain/discomfort?

- ☐ Less than 1 hour per day
- ☐ Between 1 and 4 hours per day
- ☐ Between 4 and 8 hours per day
- ☐ Almost anytime that you are not lying down
- ☐ Almost 24 hours per day
- ☐ Other________________________________

Since your symptoms began, have they ☐ improved ☐ worsened ☐ stayed the same?

What made your current symptoms worse?____

What made your current symptoms better?____

Is your sleep disturbed by these symptoms? ☐ YES ☐ NO

If you are restricted/limited or have difficulties in any activities or performance of your work because of your discomfort/pain, please describe in detail ☐ YES ☐ NO

____

____

____

If you are restricted/limited or have difficulties in any activities or performance at your home/activities of daily living or recreational activities because of your discomfort/pain, please describe in detail(such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.) ☐ YES ☐ NO

____

____

____

____

Have you done anything to try to help or relieve your complaint, such as rest, heat, cold, aspirin, medication, sit, lie down. Or other?
☐ YES ☐ NO Describe in detail____

____

Are you doing any corrective exercises for your present symptoms? ☐ YES ☐ NO
If yes, who recommended them?____________________ Briefly describe the exercises/stretches you are doing

____

Do you participate in other exercises (aerobics, walking, jogging, etc.)? ☐ YES ☐ NO
If yes, what type and how many times per week/month______________________________

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic?
☐ YES ☐ NO If yes, please list each doctor individually

A. If yes, whom did you see? Doctor's Name:____________________ Specialty:____________________
Address:______________________City__________State_______Phone__________
When were you seen? From__________to__________ Are you still under this doctor's care? ☐ Yes ☐ No

B. Were ☐ X-ray ☐ MRI ☐ CAT Scan ☐ EMG ☐ Bone scan or others______________________ taken?
What was diagnosis?____
What type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others)______________________________

____

C. How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

A. If yes, whom did you see? Doctor's Name:____________________ Specialty:____________________
Address:______________________City__________State_______Phone__________
When were you seen? From__________to__________ Are you still under this doctor's care? ☐ Yes ☐ No

B. Were ☐ X-ray ☐ MRI ☐ CAT Scan ☐ EMG ☐ Bone scan or others______________________ taken?
What was diagnosis?____
What type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others)______________________________

____

C. How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

A. If yes, whom did you see? Doctor's Name:____________________ Specialty:____________________
Address:______________________City__________State_______Phone__________
When were you seen? From__________to__________ Are you still under this doctor's care? ☐ Yes ☐ No

B. Were ☐ X-ray ☐ MRI ☐ CAT Scan ☐ EMG ☐ Bone scan or others______________________ taken?
What was diagnosis?____
What type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others)______________________________

____

C. How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

Have you seen a physical therapist for this problem? ☐ YES ☐ NO
If yes, whom did you see? Name:________________ Address:________________
What type of therapies were received? ________________
How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

Have you seen a physician, chiropractor or physical therapist for any other problems? ☐ YES ☐ NO
If yes, please describe________________
____

Have you ever been involved in injuries from following:
☐ Automobile accident ☐ Worker's compensation ☐ Personal injuries (slip and fall, etc.)
☐ Yes ☐ No If yes, please list all of them with date, type, and legal status

Injury	Date	Settled	Not settled	Attorney's name

Please list all medications (including birth control pills, aspirin, cortisone or vitamins), even if only occasionally, include how often you take the medication, how much you take, and/how long you have taken it.

Medication	How often	How much	For how long

Are you allergic to anything (medications, lotion, etc.)? ☐ YES ☐ N0
If yes, to what?________________

Do you smoke or use any tobacco products? If yes, how much & often?________________
Do you drink alcoholic beverages? If yes, how Much & often?________________
Do you drink caffeinated beverages? If yes, how much & often?________________
Please circle your level of formal education group:

- ☐ Less than High School
- ☐ High School Diploma or GED
- ☐ Some College
- ☐ College Degree
- ☐ Advanced Degree
- ☐ Vocational Training in________________

Have you missed any work as a result of this illness/pain? ☐ YES ☐ NO
If yes, how many days/weeks?________________ Dates of absence________________to________________

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Review of Systems

Circle if the symptom has occurred in the last year.
Place a check mark if the symptom has occurred in the past.

General ___ **No Problems**	Weight gain Weight loss Significant weight loss or gain History of dieting	Chronic fatigue Fatigue in the afternoon Weakness Excessive thirst Intolerance to heat	Spontaneous sweating Night sweats Fever/Chills Sick more than 1 time/year	Intolerance to cold Cold hands/feet Other:
Skin ___ **No Problems**	Dry skin Itchy skin Rashes Hives Moist skin Bruising easily	Acne Eczema Psoriasis Shingles Ringworm Changes to nails	Athlete's foot Moles Bumpy skin on back of arms Spider/varicose veins Changes to skin color	Changes to moles Nail fungus Nail ridges Other:
Head ___ **No Problems**	Headaches Migraines Hair loss	Dizziness Vertigo Trauma	Other:	
Eyes ___ **No Problems**	Dry eyes Watery eyes Itchy eyes Eye pain Red eyes Discharge from eyes	Floaters/Hallo/flashes Blurred vision Impaired vision Double vision Eyes sensitive to light Poor night vision	Sties Cataracts Vision loss Other:	Vision correction: ____________ Vision: Near__ Far__ Contacts Glasses Laser
Ears ___ **No Problems**	Ear pain Itchy ears Waxy ears	Discharge from ear Ringing in ears Hearing loss	Ear infections Ear infections as a child	Other:
Nose & Sinuses ___ **No Problems**	Itchy nose Discharge from nose Congested nose/sinuses	Postnasal drip Nosebleeds Loss of smell Breathe through mouth	Snore Other:	
Mouth & Throat	Dry mouth Itchy mouth/throat Sores on mouth/lips Hay fever/allergies Bad breath	Frequent sore throat Coughing up blood Persistent cough Difficulty swallowing Loss of Taste Hoarseness	Dentures Inflamed/bleeding gums Cavities Braces Teeth sensitivity	Jaw clicks TMJ Other dental concerns Treatment for strep. infections as a child Other:
Neck ___ **No Problems**	Neck pain or stiffness Trauma	Swollen glands	Other:	
Respiratory ___ **No Problems**	Shortness of breath Wheezing Pain with breathing Chronic cough Coughing up blood	Asthma Allergies Bronchitis/ pneumonia Positive TB test History of smoking	Exposure to chemicals Exposure to solvents Exposure to particulates	History of second-hand smoke Other:
Cardiovascular ___ **No Problems**	High blood pressure Low blood pressure High cholesterol High glucose Chest pain Heaviness in legs Cold hands/feet Varicose veins	Feel heart racing Chest tightness Difficulty breathing at night Palpitations Swelling in ankles Heart fluttering Purple fingers/lips	Irregular heartbeat Heart murmur Dizziness upon standing Exhaustion with minor Exertion Hemorrhoids Spider veins	Calf pain at night Calf pain walking Other:
Gastrointestinal ___ **No Problems**	Poor appetite Excessive appetite Changes in appetite Excessive thirst Trouble swallowing Stomach pain Nausea/ vomiting Vomiting blood Burping/ belching Abdominal pain Abdominal bloating Gas/flatulence Indigestion Heartburn/ Antacid use	Constipation (<1 stool/day) Stools that are hard to pass Foul-smelling stools Loose stools (break up when hit water) Diarrhea Blood in stools Black tar in stools Mucous in stools Undigested food in Stools Gallbladder disease	Stool shape: One piece Hard little pellets Breaks up when in water Color: Yellow Green Light brown Dark brown Treated for parasites Ulcers Hemorrhoids	Intolerance to specific foods Fatigue after eating Food sensitivity Anal itching Liver disease Other:

Review of Systems *(continued)*

Circle if the symptom has occurred in the last year.
Place a check mark if the symptom has occurred in the past.

Neurological ___ **No Problems**	Fainting Dizziness/vertigo Numbness or tingling Trembling hands Loss of grip strength	Head trauma Poor concentration Memory loss Lack of mental alertness Loss of muscle tone	Muscle weakness Heavy head Heavy extremities	Other:
Urinary ___ **No Problems**	Frequent urination Urinate < 3 times/day Can't hold urine Urination with cough or sneeze Dripping after urination	Light yellow urine Yellow urine Yellow dark urine Red urine Cloudy urine Strong smelling urine	Kidney or bladder infections Urination at night Painful/burning Urination Bed-wetting	Other:
Musculoskeletal ___ **No Problems**	Pain in: Arms Shoulders Upper back Lower back Legs Hips Neck Hands Feet	Painful bones Tight shoulder muscles Swollen knees/elbows Numbness Tingling Burning Spasms/cramps Morning stiffness Arthritis Herniated/slipped disk	Chronic pain Loss of height Unable to sit straight Activities limited due to pain Tendonitis Osteoporosis Broken bone	Other:
Women Only ___ **No Problems**	Age of first menses: Length of period: Length of cycle: Date of last menses: Heaviest flow day: # of pads/tampons on Heaviest day: Abnormal Pap?	# of pregnancies: # of live births: Currently sexually active? Yes___ No___ Which gender are you sexually active with? Men___Women___ Both___ Type of birth control: Type of STD control: Condoms Monogamy Other	Spotting between periods Clots with period Menstrual cramps Weight gain with period PMS Irritability Moodiness Crave sweets Tendency to cry Bloating/ swelling Breast tenderness Low back pain Fatigue with period Missed periods Irregular periods Difficulty conceiving Lack of sexual drive	Vaginal itching Vaginal discharge Vaginal odor Yeast infections Vaginal mucosa dry Painful intercourse/ masturbation History of STDs? Yes / No Have been tested for STDs? Yes / No Uterine cyst/fibroids Hysterectomy Use of birth control pill for greater than 10 years
Women Only	Monthly breast self-exam Yes / No Fibrous breast Breast feed your child Breast implants History of mammograms Abnormal mammogram Nipple discharge	Hot flashes Vaginal dryness Changes in cycle Moodiness Brain fog Menopause Age of menopause: Use of hormone replacement	Other:	
Men Only ___ **No Problems**	Sense of full bladder Difficulty urinating Burning/pain with urination Wake up to urinate Dripping after urination Increased straining with urination	Discharge from penis Sore on penis History of STDs? Yes / No Have been tested for STDs? Yes No Premature ejaculation Painful ejaculation Erectile dysfunction Infertility Lack of sexual drive Sexual difficulties	Testicular lump Testicular pain Breast lump Monthly testicular/breast exam History of prostatitis Enlarged prostate Have had a prostate exam Have had a PSA Prostate cancer Pain/cold in genital area Hernias	Currently sexually active? Yes / No Which gender are you sexually active with? Men / Women / Both Type of birth control: Type of STD control: Condoms Monogamy Other:

Preventive Health Care

Please indicate the last time you had the following exam.

Preventive Care	Date	Results	Doctor	Phone Number
Physical exam				
Blood pressure				
Blood tests				
Urinalysis				
Stool tests				
Rectal exam				
Colonoscopy				
Skin exam				
Dental exam				
PAP/Pelvic exam				
Mammogram				
Bone density test				
Testicular exam				
PSA/prostate exam				
STD tests				
Chest x-ray				
EKG				
Tetanus booster				
TB skin test				
Vision/Glaucoma exam				
Hearing exam				
Monthly breast self examination				

Activities of Daily Living

Activity	How often per day, week, month, always, never	Activity	How often per day, week, month, always, never	Activity	How often per day, week, month, always, never
Coffee/ black tea		# of meals per day		# of hours of sleep	
Soda		# of 8 oz glasses of water per day		Once up, feel rested	
Tobacco		Eat red meat		Difficultly going to sleep	
Alcohol		Eat chicken		Difficulty staying asleep	
Recreational drugs		Eat fish		Difficulty waking up	
Physical activity/ exercise		Eat fresh vegetables		Take time for yourself	
Drive with seat belt		Eat fruit		Watch TV	
Brush teeth		Eat dairy products		Participate in friendships, community, support groups	
Dental floss		Eat refined wheat		# hours in a car or bus	
Wear sunscreen		Eat products with sugar added		Sexually active with partner	
Exposed to chemicals		Eat whole grains		Form of contraception	
# hours per week at work		# of bowel movements		Number of sexual partners	
# of vacations per year		# of times urinate		Does a condition limit your activities?	

Past Medical History

Please check and provide the date of occurrence for the following conditions.

Condition	Date of occurrence or diagnosis	Condition	Date of occurrence or diagnosis	Condition	Date of occurrence or diagnosis
AIDS		Glaucoma		Rheumatic fever	
Alcoholism		Hepatitis		Scarlet fever	
Anemia		Hernia		Sexually transmitted disease	
Anorexia		Herpes		Stroke	
Appendicitis		High cholesterol		Suicide attempt	
Arthritis		Kidney disease		Thyroid problems	
Asthma		Liver disease		Tonsillitis	
Bleeding disorders		Measles		Tuberculosis	
Breast lump		Migraine headaches		Typhoid fever	
Bronchitis		Miscarriage		Ulcers	
Bulimia		Mononucleosis		Vaginal infections	
Cancer		Multiple sclerosis		History of motor vehicle accidents	
Cataracts		Mumps		History of physical trauma	
Chemical dependency		Pacemakers		History of physical abuse	
Chicken pox		Pneumonia		History of sexual abuse	
Diabetes		Polio		History of verbal abuse	
Emphysema		Prostate problems		History of violence	
Epilepsy		Psychiatric care		Exposure to toxins	

Serious Illnesses/Emergency Room Services/ Hospitalizations/ Surgeries/ Inpatient Services			**Pregnancy History** Please list all live births, miscarriages, and abortions	
Date	**Hospital**	**Reason**	**Date**	

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Family History

Relation	Age	State of health	Age of Death	Cause of Death		Condition	Do any of your blood relations have any of the following diseases?
Mother						Arthritis, gout	
Stepmother						Asthma	
Father						Bleeding tendency	
Stepfather						Cancer	
Brothers/ stepbrothers						Chemical dependency/ alcoholism	
						Diabetes	
						Epilepsy	
Sisters/ stepsisters						Heart disease/ strokes	
						High blood pressure	
						High cholesterol	
Children/ stepchildren						Hearing loss	
						Kidney disease	
						Mental health issues	
						Osteoporosis	
						Tuberculosis	
						Suicide	
						Other inheritable Conditions	

Who is filling out this questionnaire? ☐ Self ☐ Spouse ☐ Parent ☐ Other: ____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature____ Date_____________________________________

Physician's Signature(upon review)____________________________ Date_____________________________________
Jonathan A. Truhlar, D.C.

OFFICE USE ONLY

PHYSICIAN'S NOTES:

HISTORY IS TAKEN FROM ª PATIENT ª SPOUSE ª PARENT ª OTHER: ____
INFORMATION IS ª RELIABLE ª NOT RELIABLE ª SATISFACTORY ª NOT SATISFACTORY.
*ADDITIONAL COMMENT ª NO ª YES*____
____
____
____
____