HEALTH QUESTIONNAIRE

Patient Name: _____

Patient Nickname: _____

PATIENT INFORMATION:

Today Date: _____

Patient's Home Address

Street:
City, State Zip:
Email:
Phone:

Cell Phone: _____

Employer Business Address

Name:
Street:
City, State Zip:
Email:
Phone:
Occupation:

Social Security #: _____ - _____ - _____

Date Of Birth: _____/_____/_____

Sex: ☐ - Male ☐ - Female

Marital Status: S M W D Other:_____

Patient Resides With: ☐ - Lives Alone

☐ - Spouse ☐ - Children ☐ - Parents

☐ - Significant Other

Children: ☐ - Yes ☐ - No

Ages and Gender: _____ M F

_____ M F

_____ M F

_____ M F

_____ M F

Spouse's Name: _____

Spouse SS#: _____

Spouse Age: _____

Referred By: _____

or **How Did You Hear Of Us:** _____

CONCERNS:

1 What is your Primary Concern?

☐ - None, seeking WELLNESS only!

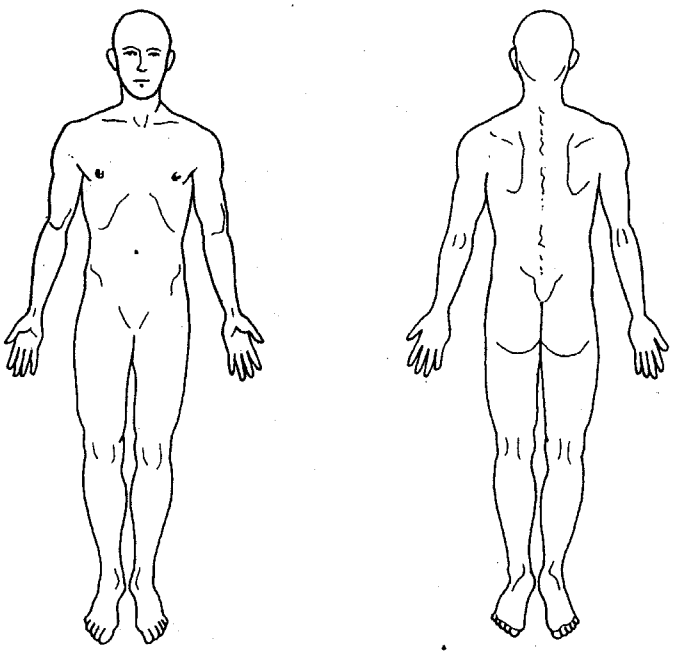
Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

How would you rate your symptoms today with 0 being no pain and 10 being the worst pain: ____

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



CONCERNS: (Continued)

When did your symptoms begin? _____

IF your complaints include pain, is it aggravated by?

☐ - Coughing ☐ - Lifting
☐ - Sneezing ☐ - Bending
☐ - Straining At Stool ☐ - Sitting
☐ - Neck Movement ☐ - Standing
☐ - Reaching ☐ - Walking

IF your complaints include pain, is it relieved by?

☐ - **NOTHING** ☐ - Heat ☐ - Sitting
☐ - Rest ☐ - Stretching ☐ - Standing
☐ - Ice ☐ - Exercise
☐ - Other_____

Are you getting: ☐ - Better ☐ - Worse ☐ - Same

Who else have you seen for this condition?

☐ - Chiropractor : _____
☐ - MD: _____
☐ - Orthopedist: _____
☐ - Other: _____
☐ - None Of The Above

Since symptoms began, noticed any changes in:

☐ - Bowel Function: _____
☐ - Bladder Function: _____
☐ - Sexual Function: _____
☐ - Other: _____
☐ - No Changes In The Above

REVIEW OF SYSTEMS:

1. Are you presently suffering from (or recently have had) any of the following?

a. General ☐ - **NORMAL**
☐ - Fatigue ☐ - Chills
☐ - Weakness ☐ - Weight Change
☐ - Fever ☐ - Night Sweats
☐ - Loss of Sleep ☐ - Other _____

b. Skin ☐ - **NORMAL** ☐ - Eczema
☐ - Rash ☐ - Hair Changes
☐ - Redness ☐ - Nail Changes
☐ - Itching ☐ - Bruise Easily
☐ - Dryness ☐ - Other _____

c. Neurologic ☐ - **NORMAL**
☐ - Headache ☐ - Seizures
☐ - Dizziness ☐ - Nervousness
☐ - Fainting ☐ - Other _____

d. Eyes/Ears ☐ - **NORMAL**

	right	left
New Vision/Hearing Trouble	☐	☐
Pain	☐	☐
Discharge	☐	☐
Other _____	☐	☐

e. Nose/Mouth/Throat ☐ - **NORMAL**
☐ - Pain ☐ - Absence of Smell/Taste
☐ - Bleeding ☐ - Enlarged Glands
☐ - Sinus Problems ☐ - Tonsillitis
☐ - Infections ☐ - Other _____

f. Psychological ☐ - **NORMAL**
☐ - Anxiety/Depression ☐ - Other _____

g. Heart/Lungs ☐ - **NORMAL**
☐ - Difficulty Breathing
☐ - Swollen Extremities
☐ - Cough/Wheeze
☐ - Blue/Red Skin Changes
☐ - Other _____

h. Breasts ☐ - **NORMAL**
☐ - Pain
☐ - Redness/Itching
☐ - Lumps/Dimpling
☐ - Discharge
☐ - Other _____

i. Stomach/Digestion ☐ - **NORMAL**
☐ - Appetite Changes
☐ - Pain ☐ - Diarrhea
☐ - Vomiting ☐ - Constipation
☐ - Other _____

j. Genitourinary ☐ - **NORMAL**
☐ - Painful Urination
☐ - Frequent Urination
☐ - Bedwetting
☐ - Irregular/Painful Menstruation
☐ - Conception/Pregnancy Probs.
☐ - Other _____

k. Endocrine ☐ - **NORMAL**
☐ - Goiter ☐ - Tremor
☐ - Sugar in Urine
☐ - Other _____

What hobbies/sports do you participate in & how often?

1.) _____
2.) _____
3.) _____

Health Habits?

Smoking	☐ - NEVER	☐ - Moderate	☐ - Frequent
Alcohol	☐ - NEVER	☐ - Moderate	☐ - Frequent
Exercise	☐ - NEVER	☐ - Moderate	☐ - Frequent
Recr. Drugs	☐ - NEVER	☐ - Moderate	☐ - Frequent

MEDICAL HISTORY:

1. Health Care	Y	N
a. Have you ever been to a Chiropractor before?	☐	☐
b. Do you have a Family Physician?	☐	☐
Name & Phone: _____		
c. Have you ever been hospitalized?	☐	☐
d. Have you ever had surgery?	☐	☐
e. Have you ever had a SERIOUS accident	☐	☐
f. Women Only:		
Are you possibly pregnant right now?	☐	☐
Are you seeing an OB-GYN regularly?	☐	☐
g. Are you currently taking ANY medication	☐	☐

List ALL w/dosage amounts if known:

_____
_____
_____
_____
_____

2. Do you NOW have or HAVE had any of the following:

☐ - Allergies	☐ - High Blood Pressure
☐ - Asthma	☐ - Tuberculosis
☐ - Bone Fracture	☐ - Pacemaker
☐ - Cancer	☐ - Prostate Trouble
☐ - Diabetes	☐ - Scoliosis
☐ - Dislocated Joints	☐ - Spinal Disease
☐ - Epilepsy	☐ - Ulcer

☐ - Other _____

3. Family History: Please list **ANY** health problems below:
(such as: Cancer, Diabetes, Heart Disease, Headaches, Back or Neck Problems, Stroke, Arthritis, Scoliosis, etc)

Grandparents:_____
Father:_____
Mother:_____
Brother/Sister:_____
Spouse:_____
Children:_____

ACTIVITIES OF DAILY LIVING:

1. Job Type: ☐ - Full Time ☐ - Part Time ☐ - Temp ☐ - Other

2. Hours Per Week (Typical): _____

3. Do your complaints affect your ability or quality of work? ☐ - Yes ☐ - No

4. Right or Left Handed? ☐ - R ☐ - L

5. What is your STRESS level usually?
☐ - None ☐ - Low ☐ - Med. ☐ - High

INSURANCE INFORMATION:

1. Is your condition due to:	Y	N
Automobile Accident	☐	☐
Personal Injury	☐	☐
Job Injury	☐	☐
Unknown Onset	☐	☐

2. Authorization to release records to Patient's Insurance Carrier:

Signature:

X

PAYMENT:

I do hereby authorize Andreone Sports & Family Chiropractic to administer such care that is necessary for my particular case. I further agree to pay for services rendered as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's or Guardian's Signature:

X _____

Date