Health Questionnaire

Date: ___________________________

Patient Name: ____ Date of Birth: __________________________________

List any medications and supplements you take, as well as the associated condition for each:

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List any surgeries or hospitalizations you have had, including month and year of each:

____

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____

List anything you are allergic to: ____

Do you exercise? Yes No Hours per week: ______________ What activities? ________________________________

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Do you smoke? Yes No Packs per day: ___________ How many years have you been smoking? ____________

Do you drink alcoholic beverages? Yes No Drinks per day: ______________

For women: Are you pregnant or nursing? Yes No If pregnant, how many weeks: ______________

Medical History

Describe the reason(s) for your doctor visit today:

____

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Are you here because of an accident? Yes No What type? ____

How often do you experience symptoms? Daily 4-5X per week 3-4X per week 1-2X per week

Describe your symptoms (Circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms: Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? ___________________________________

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Have you experienced these symptoms in the past? ____

____

History of Treatment

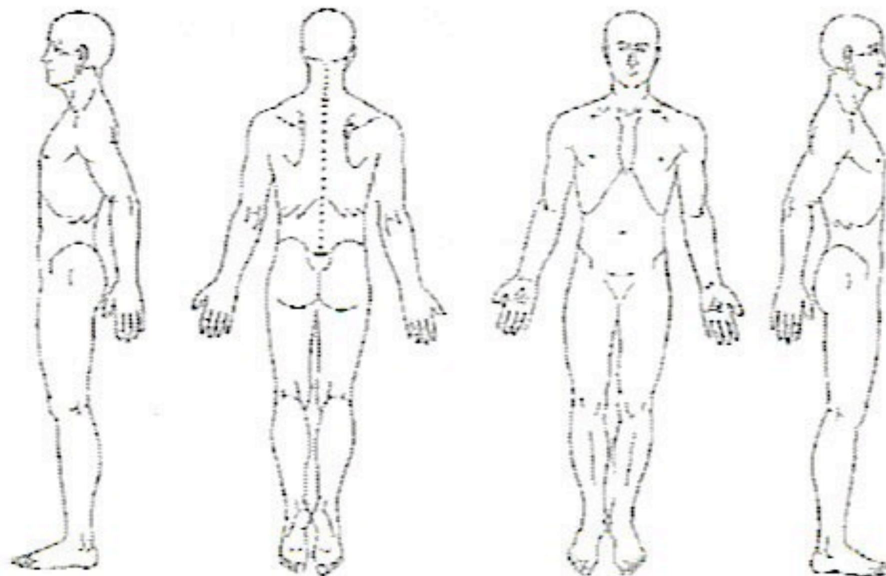
Have you seen a chiropractor before? Yes No Who referred you to us today: ___________________________

Have you seen another doctor for these symptoms? Yes No If yes, indicate name and type of medical provider: ____

Description of Condition

Mark any area(s) of discomfort with the following key:

A = Ache N = Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

For the conditions below, please indicate if you have had the condition in the past or if you have the condition now.

Past	Now	Condition
		Abdominal pain
		Abnormal weight gain/loss
		Allergies
		Angina
		Ankle/foot pain

Past	Now	Condition
		Arthritis
		Asthma
		Bladder infection
		Cancer
		Chest pains
		Chronic sinusitis

Past	Now	Condition
		Depression
		Dermatitis/Eczema
		Dizziness
		Drug/Alcohol use
		Elbow/Upper arm pain
		Epilepsy

Past	Now	Conditon	Past	Now	Condition	Past	Now	Condition
		Excessive thirst			Jaw pain			Painful urination
		Frequent urination			Joint swelling/stiffness			Prostate problems
		General fatigue			Kidney stones			Shoulder pain
		Hand pain			Knee/Lower leg pain			Smoking/tobacco use
		Headache			Liver/Gall bladder			Stroke
		Heart attack			disorder			Systematic lupus
		Hepatitis			Loss of bladder control			Thoracic outlet syndrom
		High blood pressure			Low back pain			Tumor
		Hip/Upper leg pain			Mid back pain			Ulcer
		HIV/AIDS			Neck pain			Upper back pain
								Wrist pain

Additional comments you would like the doctor to know: ______________________________

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______________________________ Patient Signature

______________________________ Doctor Signature