



File #: \_\_\_\_\_

Date: \_\_\_\_\_

# Health Questionnaire

Dear Patient,

Welcome to Family Chiropractic Health Center. For our records and for your convenience, please answer the following questions. The doctors and staff will review the information you provide on your first visit. It is important to answer these questions to the best of your ability. Thank you.

## Patient Demographic Information

Name: \_\_\_\_\_  
Last name First name Middle Initial

Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Number: (\_\_\_\_) \_\_\_\_\_  
 Mobile Phone: (\_\_\_\_) \_\_\_\_\_  
 Gender:  Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Driver's License #: \_\_\_\_\_  
 How were you referred to Family Chiropractic Health Center?: \_\_\_\_\_  
 Marital Status:  Single  Married  Widowed  Divorced  Separated  
 Spouse/Partner's Name: \_\_\_\_\_  
 Spouse/Partner's Employer: \_\_\_\_\_  
 Spouse/Partner's Work Phone: \_\_\_\_\_  
 Other Nearest Relative or Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
 E-mail Address(optional): \_\_\_\_\_  
 • If you reside at a second address during part of the year, please provide the information below:  
 Second Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_  
 Months at this address:  
 Jan  Feb  March  April  May  June  July  Aug  Sep  Oct  Nov  Dec

## Patient Information

Have you received chiropractic care in the past?  Yes  No  
 Please give the date of your last visit, the name of the doctor, and the reason for the previous care: \_\_\_\_\_

Are you a Medicare patient?  Yes  No  
 If so, please state your secondary insurance carrier: \_\_\_\_\_

Are you a Medicaid patient?  Yes  No  
 Are you filing for a Workers Compensation case?  Yes  No  
 Are you filing for a personal injury case?  Yes  No  
 If you a minor (under the age of 18) Please state the name(s) of your parent(s) or legal guardian(s): \_\_\_\_\_

## Patient Condition/Major Complaint(s) Information

Reason(s) for your visit today: \_\_\_\_\_

Is this due to and accident?  Yes  No;  Auto  Work  Home  Other Date : \_\_\_\_\_

Patient's Initials: \_\_\_\_\_

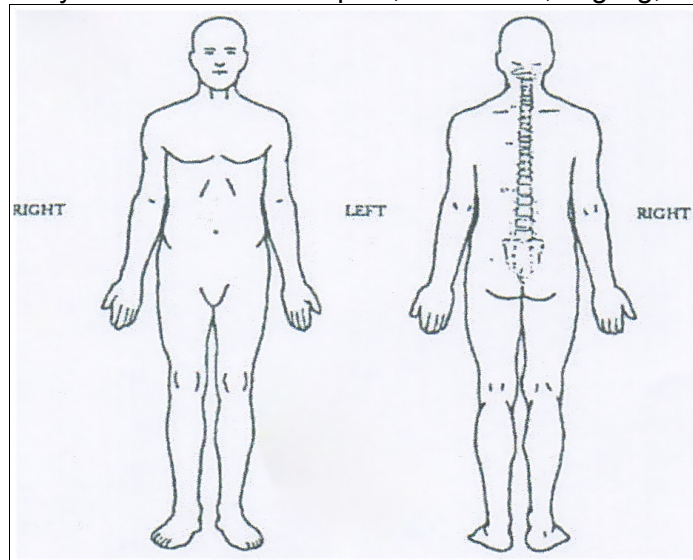
Have you reported this to your: Insurance company:  Yes  No and/or Employer:  Yes  No  
When did your symptom(s) begin? \_\_\_\_\_  
Have you experienced these symptoms before?  Yes  No. When? \_\_\_\_\_

Is this condition getting:  Better  Worse  Staying the same  
What makes this condition worse: \_\_\_\_\_  
What makes this condition better: \_\_\_\_\_

Does it interfere with your:  
 Work  Sleep  Self Care  Daily Routine  Recreation  
Activities or movements that are difficult/painful to perform:  
 Lying on back  Getting in/out of car  Sleeping  Stooping  Standing for a long time  
 Lying on side  Gripping/reaching  Pushing  Sitting  Sneezing  
 Turning over  Climbing  Pulling  Bending  Coughing  
 Lying flat  Dressing  Washing  Walking  Sexual Activity  
 Other: \_\_\_\_\_

What treatment(s) have you already received for your condition?  
 Chiropractic  Medications  Surgery  Physical Therapy  None  Other:  
Name of other doctor(s) who has treated you for this condition: \_\_\_\_\_  
Were you Satisfied:  Yes  No

Mark your pain on the below scale 0 to 10:  
(At rest) No Pain ☺ 1 2 3 4 5 6 7 8 9 10 Extreme Pain/ No Function  
(With Activity) No Pain ☺ 1 2 3 4 5 6 7 8 9 10 Extreme Pain/ No Function  
Mark on the picture where you continue to have pain, numbness, tingling, etc...



### Personal Health History

Are you currently under the care of a healthcare provider or any other doctor?  Yes  No  
If yes, please give the date of your last visit and for what condition(s): \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of previous chiropractor: \_\_\_\_\_

Have you ever been treated for a spine/nerve disorder:  Yes  No  
Explain: \_\_\_\_\_

Patient's Initials: \_\_\_\_\_

Date of Last:

Chiropractic Exam: \_\_\_\_\_ X-Ray: \_\_\_\_\_ Cholesterol: \_\_\_\_\_  
 Prostate/PSA: \_\_\_\_\_ Mammogram: \_\_\_\_\_ Pap Smear: \_\_\_\_\_  
 Stool check for blood: \_\_\_\_\_ Colonoscopy: \_\_\_\_\_ Eye Exam: \_\_\_\_\_  
 MRI: \_\_\_\_\_ Purpose: \_\_\_\_\_  
 CT-Scan: \_\_\_\_\_ Purpose: \_\_\_\_\_

Do you currently wear any of the following:  
 Heel Lifts    Innersoles    Arch Supports    Orthotics    Braces    Wraps

Do you use a cane or a crutch?  Yes    No

Rate each of these areas on a scale of 0 to 10

<i>Stress level:</i> No Stress	☺	1	2	3	4	5	6	7	8	9	10	Very Stressed
<i>Exercise:</i> High Intensity	☺	1	2	3	4	5	6	7	8	9	10	No Exercise at all
<i>Activity:</i> Normal Daily Activity	☺	1	2	3	4	5	6	7	8	9	10	Stuck in Bed
<i>Sleep:</i> Wake-up Fully Rested	☺	1	2	3	4	5	6	7	8	9	10	No/poor sleep
<i>Appetite:</i> Normal Appetite	☺	1	2	3	4	5	6	7	8	9	10	No Appetite
<i>Mood:</i> Happy & Relaxed	☺	1	2	3	4	5	6	7	8	9	10	Depressed/Nervous

In what position do you sleep?    Back    Side    Stomach  
 Do you sleep with a pillow?    Yes    No    If so how many? \_\_\_\_\_

## Past, Family, Social & Occupational History

### Medication(s): List ANY/ALL medications you are CURRENTLY taking. BE SPECIFIC

Medication	Dosage	For what condition?	Length of time taken

### Supplements: List ANY/ALL non-prescription items you are CURRENTLY taking. BE SPECIFIC

Vit., Minerals, Herbs, etc...	Dosage	For what condition?	Length of time taken

### Child & Adult Illness(es); List all past health conditions. Indicate if any are still present.


### Surgery(ies): List all Surgical Procedures with the date of the procedure was performed.


Patient's Initials: \_\_\_\_\_

**Females ONLY: Mark all that apply below**

**Menstrual History:**

- I...  Currently have menses  Currently DO NOT have menses  
My menses...  Are regular  Are NOT regular  
Age of first menses: \_\_\_\_\_ Date of last menses: / /

If you have been pregnant in the past, please fill in the appropriate information below:

- \_\_\_\_\_ Number of complicated pregnancies \_\_\_\_\_ Number of uncomplicated pregnancies  
\_\_\_\_\_ Number of C-sections \_\_\_\_\_ Number of vaginal deliveries  
\_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Number of terminated pregnancies  
I...  AM CURRENTLY PREGNANT  AM CURRENTLY NOT PREGNANT

**Injury (ies):** List all injuries. Write the date of the injury immediately afterward and explain.

**Allergies: Mark ALL that apply below.**

- |  |   |                                       |                                      |
|--|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Feathers       | <input type="checkbox"/> Nuts         | <input type="checkbox"/> Soap        |
| <input type="checkbox"/> Animals       | <input type="checkbox"/> Food Coloring  | <input type="checkbox"/> Perfumes     | <input type="checkbox"/> Soy         |
| <input type="checkbox"/> Bee Sting     | <input type="checkbox"/> Gluten (wheat) | <input type="checkbox"/> Pollen       | <input type="checkbox"/> Wheat       |
| <input type="checkbox"/> Chocolate     | <input type="checkbox"/> Latex          | <input type="checkbox"/> Shellfish    | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Dairy         | <input type="checkbox"/> Mold           | <input type="checkbox"/> Strawberries | <input type="checkbox"/> Other:      |
| <input type="checkbox"/> Eggs          | <input type="checkbox"/> Newsprint      | <input type="checkbox"/> Smoke        |                                      |

Describe the reaction YOU experience with any of the above: \_\_\_\_\_

**Social History:**

- Do you have any concerns about you sexual health?  Yes  No  
Are you or have you ever been a victim of domestic or sexual abuse?  Yes  No

**Diet/Nutrition:**

Are you on any special diet?  Yes  No

If yes, for what reason: \_\_\_\_\_

Is your weight a concern for you emotionally or physically?  Yes  No

Have you gained or lost over 10lbs in the past six months without trying?  Yes  No

Rate your diet on a scale of 0 to 10:

(good) ☺ 1 2 3 4 5 6 7 8 9 10 (Bad)

How many 8oz. Glasses of water do you drink a day? \_\_\_\_\_

How many caffeine drinks do you drink per day? (Soda, coffee, tea, etc.) \_\_\_\_\_

**Habits:**

- Tobacco Use: Now?  Yes  No Amount /week \_\_\_\_\_ How long? \_\_\_\_\_ Years/months  
(smoking/smokeless Past)?  Yes  No Amount /week \_\_\_\_\_ How long? \_\_\_\_\_ Years/months  
 Quit Date: \_\_\_\_\_  
Alcohol Use: Now?  Yes  No Amount /week \_\_\_\_\_ How long? \_\_\_\_\_ Years/months  
Past?  Yes  No Amount /week \_\_\_\_\_ How long? \_\_\_\_\_ Years/months

**Occupational History:**

Occupation:  Working  Retired  Unemployed  Student

Employer/School: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_

Work Activity:  Sitting  Standing  Twisting  Bending  Light labor  Heavy Labor

Explain if you have ever been injured on the job: \_\_\_\_\_

Patient's Initials: \_\_\_\_\_

**Educational History:** Mark the highest level of education completed below:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Elementary School        | <input type="checkbox"/> Vocational School | <input type="checkbox"/> Graduate School                           |
| <input type="checkbox"/> Middle School            | <input type="checkbox"/> College           | <input type="checkbox"/> Graduate Degree                           |
| <input type="checkbox"/> High School (incomplete) | <input type="checkbox"/> Associates Degree | <input type="checkbox"/> Doctorate                                 |
| <input type="checkbox"/> High School graduate     | <input type="checkbox"/> Bachelors degree  | <input type="checkbox"/> GED <input type="checkbox"/> Other: _____ |

**Family History:**

<i>Relation</i>	<i>Alive/Deceased</i>	<i>Age(now/at death)</i>	<i>Significant illness / cause of death</i>

**Other Information:**

## Review of Systems

-Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect the overall course of care.

**Constitutional:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |   |                                  |                                       |                                      |
|---|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Chills             | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Daytime Drowsiness | <input type="checkbox"/> Fever   | <input type="checkbox"/> Weight Gain  |                                      |

**Eyes/Vision:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Blindness        | <input type="checkbox"/> Double Vision            | <input type="checkbox"/> Itching                |
| <input type="checkbox"/> Blurred Vision   | <input type="checkbox"/> Eye Pain                 | <input type="checkbox"/> Photophobia            |
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Field Cuts               | <input type="checkbox"/> Tearing                |
| <input type="checkbox"/> Change in vision | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Wear Glasses/Contacts: |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Headaches (at same time) | Type of correction: _____                       |

**Ears, Nose and Throat:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Bleeding              | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Nasal Congestion           | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Dentures              | <input type="checkbox"/> Frequent sore throats  | <input type="checkbox"/> Nosebleeds                 | <input type="checkbox"/> Other:       |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Postnasal Drip             |                                       |
| <input type="checkbox"/> Discharge             | <input type="checkbox"/> Hearing Loss           | <input type="checkbox"/> Rhinorrhea (runny nose)    |                                       |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> History of Head Injury | <input type="checkbox"/> Sinus infections           |                                       |
| <input type="checkbox"/> Ear drainage          | <input type="checkbox"/> Hoarseness             | <input type="checkbox"/> Snoring                    |                                       |
| <input type="checkbox"/> Ear Pain              | <input type="checkbox"/> Loss of sense of smell | <input type="checkbox"/> Tinnitus (ringing in ears) |                                       |

**Respiration:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |                                     |  |  |                                   |
|-------------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Coughing up blood   | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Rib Fracture/trauma | <input type="checkbox"/> Sputum Production   | <input type="checkbox"/> Other:   |

**Cardiovascular:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |   |   |
|---|---|
| <input type="checkbox"/> Angina (chest pain/discomfort after exertion)    | <input type="checkbox"/> Palpitations (heart flutter)   |
| <input type="checkbox"/> Chest Pain                                       | <input type="checkbox"/> Paroxysmal Nocturnal Dyspnea<br>(waking at night with shortness of breath) |
| <input type="checkbox"/> Claudication (leg pain/ache)                     | <input type="checkbox"/> Shortness of breath with exertion or exercise                              |
| <input type="checkbox"/> Heart Murmur                                     | <input type="checkbox"/> Swelling of legs   |
| <input type="checkbox"/> Hypertension(High Blood Pressure)                | <input type="checkbox"/> Ulcers   |
| <input type="checkbox"/> Hypotension (Low Blood Pressure)                 | <input type="checkbox"/> Varicose Veins   |
| <input type="checkbox"/> Orthopnea (difficulty breathing when lying down) | <input type="checkbox"/> Other:   |

Patient's Initials: \_\_\_\_\_

**Gastrointestinal:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Abdominal Pain     | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Nausea          | <input type="checkbox"/> Vomiting Blood |
| <input type="checkbox"/> Belching           | <input type="checkbox"/> Heartburn             | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Other:         |
| <input type="checkbox"/> Black-Tarry Stools | <input type="checkbox"/> Hemorrhoids           | <input type="checkbox"/> Abnormal Stool  |   |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Indigestion           | Color/Character/Consistency/Amount       |   |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Vomiting        |   |

**Female:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Birth Control        | <input type="checkbox"/> Cramps             | <input type="checkbox"/> Irregular Menstruation | <input type="checkbox"/> Vaginal Bleeding  |
| <input type="checkbox"/> Breast Lumps or Pain | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Pregnancy              | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Burning Urination    | <input type="checkbox"/> Hormone Therapy    | <input type="checkbox"/> Urine Retention        | <input type="checkbox"/> Other:            |

**Male:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |   |  |  |                                 |
|---|--|--|---------------------------------|
| <input type="checkbox"/> Burning Urination    | <input type="checkbox"/> Frequent Urination  | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Hesitancy/Dribbling | <input type="checkbox"/> Urine Retention   |                                 |

**Endocrine:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Abnormal Frequency of Urination | <input type="checkbox"/> Hair Growth   |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Goiter                          | <input type="checkbox"/> Voice Changes |
| <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Hair Loss        |  |  |

**Skin:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Changes in Nail Texture | <input type="checkbox"/> Hair Loss                | <input type="checkbox"/> Itching           | <input type="checkbox"/> Varicosities |
| <input type="checkbox"/> Changes in Skin Color   | <input type="checkbox"/> Hives                    | <input type="checkbox"/> Rash              |                                       |
| <input type="checkbox"/> Hair Growth             | <input type="checkbox"/> History of Skin Problems | <input type="checkbox"/> Skin Lesion/Ulcer |                                       |

**Nervous System:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Stress                       |
| <input type="checkbox"/> Facial Weakness       | <input type="checkbox"/> Numbness           | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Headache              | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Tremor                       |
| <input type="checkbox"/> Limb Weakness         | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Uncontrollable Bowel/Bladder |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Slurred Speech     | <input type="checkbox"/> Unsteadiness of Gait/Balance |

**Psychological:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |  |  |                                     |  |                                 |
|--|--|-------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Bi-polar Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss/Change of Appetite | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Behavior Change | <input type="checkbox"/> Confusion         | <input type="checkbox"/> Insomnia   | <input type="checkbox"/> Memory Loss             |                                 |

**Allergy:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |   |   |   |                                   |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> Anaphalaxis      | <input type="checkbox"/> Itching                | <input type="checkbox"/> Chronic Nasal Congestion | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Food Intolerance | <input type="checkbox"/> Acute Nasal Congestion | <input type="checkbox"/> Rash                     |                                   |

**Hematologic:**  Patient DENIES having or have had any of the symptoms/problems in this category.

- |                                 |                                   |   |  |  |                                  |
|---------------------------------|-----------------------------------|---|--|--|----------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Blood Clotting | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Fatigue |
|---------------------------------|-----------------------------------|---|--|--|----------------------------------|

**While we will work with you, as health professionals we are also concerned about your overall wellness. On future visits we will discuss issues with you that may impact your overall health. All of the answers I have given are correct to the best of my knowledge, and I agree to have an examination performed at Family Chiropractic Health Center at this time.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Relationship

Patient's Initials: \_\_\_\_\_