

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date _____

Birthdate _____

Patient name _____

Reason for visit _____

Have you been treated before for this problem? No Yes

If yes, by Physician Doctor of Chiropractic Physical Therapist Osteopath Other _____

What did they do and/or recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No Unknown

Is it constant or does it come and go? _____ Does it interfere with your Work Sleep Daily routine Recreation

Activities or movements that are painful to perform Sitting Walking Bending Lying down

Other _____

Your Occupation _____ (Describe activities - sitting, lifting, etc.)

Have you ever had chiropractic care for other problems? No Yes When? _____

Do you take Muscle relaxers Pain killers Insulin Birth control pills Over-the-counter meds

Other prescription drugs _____ Please list all medication in the space at bottom of page.

Date of last: Physical exam _____ Spinal x-ray _____ Blood test _____

Spinal exam _____ Chest x-ray _____ Urine test _____

Dental x-ray _____ MRI, CT-scan, bone scan _____

Sleep _____ hrs/night Do you sleep on your Back Side Stomach Non-job exercise _____ hrs/wk

Age of mattress _____ or waterbed _____ Is your bed comfortable? No Yes

What kind of pillow do you use? Thick Medium Thin None Support

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

CONDITIONS Check (✓) conditions you have or have had in the past.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors, growths |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatoid arthritis | |

MEDICATIONS List medications you are currently taking

VITAMINS/HERBS/MINERALS

Allergies _____