HEALTH QUESTIONNAIRE

Dear Patient: Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ●. **Erase** changes cleanly. Do **not fold** this form.

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Date Of Birth

Email

Patient's Home Address

Phone Cell

Employer Business Address

Phone

Occupation

Referred By

Spouse Name

Sex:
- ○ Male
- ○ Female

Marital Status:
- ○ Single
- ○ Married
- ○ Widowed
- ○ Divorced
- ○ Other

Patient Resides With:
- ○ Lives Alone ○ Spouse ○ Parents
- ○ Children ○ Other

Children: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

A. MAJOR COMPLAINTS

1. What are your major complaints?

○ None	Pain	Numbness	Tingling
Head	○	○	○
Neck	○	○	○
Upper Back	○	○	○
Mid Back	○	○	○
Lower Back	○	○	○

	Pain R	Pain L	Numbness R	Numbness L	Tingling R	Tingling L
Shoulder	○	○	○	○	○	○
Arm	○	○	○	○	○	○
Forearm	○	○	○	○	○	○
Hand	○	○	○	○	○	○
Buttock	○	○	○	○	○	○
Hip	○	○	○	○	○	○
Thigh	○	○	○	○	○	○
Leg	○	○	○	○	○	○
Foot	○	○	○	○	○	○

2. Currently your pain is aggravated by
- ○ Coughing ○ Lifting
- ○ Sneezing ○ Bending
- ○ Straining At Stool ○ Sitting
- ○ Neck Movement ○ Standing
- ○ Reaching ○ Walking
- ○ Other

3. Since your symptoms began, have you noticed a change in
- ○ Bowel Function ○ Bladder Function
- ○ Ability To Maintain An Erection

B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

1. a. GENERAL
- ○ Normal ○ Chills
- ○ Fatigue ○ Weight Change
- ○ Weakness ○ Night Sweats
- ○ Fever ○ Other

b. SKIN
- ○ Normal ○ Eczema
- ○ Rash ○ Hair Changes
- ○ Redness ○ Nail Changes
- ○ Itching ○ Other

c. NEUROLOGIC
- ○ Normal ○ Fainting
- ○ Headache ○ Convulsions
- ○ Dizziness ○ Other

d. EYES

○ Normal	Right	Left
Vision Trouble	○	○
Pain	○	○
Discharge	○	○
Other	○	○

e. EARS

○ Normal	Right	Left
Hearing Trouble	○	○
Ringing	○	○
Pain	○	○
Discharge	○	○
Other	○	○

f. NOSE
- ○ Normal
- ○ Pain ○ Absence Of Smell
- ○ Bleeding ○ Other

g. MOUTH/THROAT
- ○ Normal ○ Absence Of Taste
- ○ Sores ○ Abnormal Taste
- ○ Bleeding ○ Other

h. HEART/LUNGS
- ○ Normal ○ Blue Extremities
- ○ Cough ○ Murmur
- ○ Wheezing ○ Chest Pain
- ○ Difficulty Breathing ○ Palpitations
- ○ Swollen Extremities ○ Other

i. BREASTS
- ○ Normal ○ Dimpling
- ○ Lumps In Breast(s) ○ Discharge
- ○ Redness/Itching ○ Other
- ○ Pain

j. STOMACH/INTESTINES
- ○ Normal ○ Vomiting
- ○ Decreased Appetite ○ Diarrhea
- ○ Increased Appetite ○ Constipation
- ○ Abdominal Pain ○ Other

k. REPRODUCTIVE/URINATION
- ○ Normal ○ Impotence
- ○ Inability To Hold Urine ○ Sterility
- ○ Painful Urination ○ Other
- ○ Frequent Urination
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding

l. GLANDULAR
- ○ Normal ○ Goiter
- ○ Heat/Cold Intolerance ○ Tremor
- ○ Sugar In Urine ○ Other

m. MENTAL
- ○ Normal ○ Phobias
- ○ Anxiety ○ Mood Swings
- ○ Depression ○ Other
- ○ Memory Loss or Impairment

2. What are your habits?

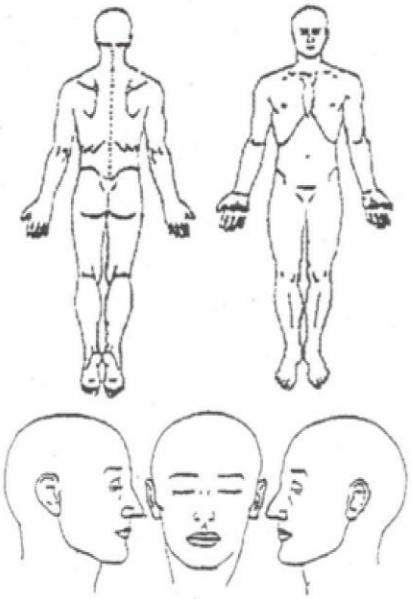
	Never	Occasionally	Moderately	Excessively
Smoking	S	S	S	S
Alcohol	A	A	A	A
Recreational Drugs	R	R	R	R
Exercise	E	E	E	E

3. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Mother	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Brothers	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
Sisters	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Children	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C

C. PAIN DIAGRAMS

Please mark the location of your pain on these figures



D. MEDICAL HISTORY

1. HEALTH CARE

	Yes	No
a. Have you been to a chiropractor	Y	N
b. Do you have a family physician	Y	N
c. WOMEN:		
To the best of your knowledge are you pregnant	Y	N
Are you under the regular care of an OB-GYN	Y	N
d. Have you been hospitalized in the past five years	Y	N
e. Are you currently taking any medication	Y	N

- ○ Anti-inflammatory (Aspirin, Motrin, etc.)
- ○ Muscle Relaxants
- ○ Pain Medication/Analgesic
- ○ Tranquilizers
- ○ Birth Control Pills
- ○ Other

2. Which of the following illnesses have you had?

- ○ *No Previous Conditions/Illnesses*
- ○ Arthritis
- ○ Asthma
- ○ Sinus Trouble
- ○ Hay Fever
- ○ Allergies
- ○ Tuberculosis
- ○ Diabetes
- ○ Epilepsy
- ○ Thyroid Trouble
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Heart Trouble
- ○ HIV/ARC
- ○ AIDS
- ○ Sexually Transmitted Disease
- ○ Ulcer
- ○ Cancer
- ○ Polio
- ○ Rheumatic Fever
- ○ Serious Injury
- ○ Bone Fracture
- ○ Dislocated Joints
- ○ Spinal Disc Disease
- ○ Multiple Sclerosis
- ○ Scoliosis
- ○ Mental/Emotional Difficulty
- ○ Prostate Trouble
- ○ Kidney Trouble
- ○ Other

E. INSURANCE INFORMATION

	Yes	No
1. Is your condition due to an automobile accident	Y	N
Date of Accident		
Have You filed an accident report	Y	N
2. Is your condition due to a job injury	Y	N
Date of Injury		
Have You filed an injury report	Y	N
3. Do you have health insurance	Y	N
Company		
Policy #		
4. Are you covered by Medicare	Y	N
Medicare #		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. 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.

F. PAYMENT

I WILL BE PAYING TODAY BY:

○ Cash ○ Check ○ Credit Card

○ MasterCard ○ Visa ○ American Express

Account # _____ Exp. Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Doctor's Signature _____ Date _____