HEALTH QUESTIONNAIRE

Patient Name: _____

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.

MO	DAY	YR
1 7	1 95	
2 8	2 96	
3 9	3 97	
4 10	4 98	
5 11	5 99	
6 12	6 00	
	10 7 01	
	20 8 02	
	30 9 03	
		04

DR#	PATIENT NUMBER
	0 0 0 0 0 0 0 0 0 0 0 0 0 0
	1 1 1 1 1 1 1 1 1 1 1 1 1 1
	2 2 2 2 2 2 2 2 2 2 2 2 2 2
	3 3 3 3 3 3 3 3 3 3 3 3 3 3
	4 4 4 4 4 4 4 4 4 4 4 4 4 4
	5 5 5 5 5 5 5 5 5 5 5 5 5 5
	6 6 6 6 6 6 6 6 6 6 6 6 6 6
	7 7 7 7 7 7 7 7 7 7 7 7 7 7
	8 8 8 8 8 8 8 8 8 8 8 8 8 8
	9 9 9 9 9 9 9 9 9 9 9 9 9 9

A. PATIENT INFORMATION

Patient's Home Address

Phone FAX

Employer Business Address

Phone

Occupation

Social Security #

Referred By

Date Of Birth **Age**

Sex: ○Male ○Female

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

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

Children:
○Yes ○No How Many? 1 2 3 4 5+

Spouse

Name

Social Security #

B. COMPLAINTS

1. What Are Your Primary Complaints? ○*None*

	LEFT SIDE								RIGHT SIDE							
	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling	
LEFT	P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S	RIGHT

2. What Are Your Secondary Complaints? ○*None*

	LEFT SIDE								RIGHT SIDE							
	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling	
LEFT	P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S	RIGHT

3. Additional Complaints? ○Yes ○No Please List:

4. When Did Your Symptoms Begin?
○Date

5. How Often Do Your Symptoms Occur?
○Occasional ○Intermittent ○Frequent
○Constant ○Other

6. How Would You Rate Your Pain Today With 0 Being No Pain and 10 Being The Worst Pain?

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

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PLEASE MAKE NO MARKS IN THIS AREA

B. COMPLAINTS (CONTINUED)

7. Are You Getting? ○Better ○Worse ○Same

8. If Your Complaints Include Pain, Is It Aggravated By?

○Coughing	○Reaching	○Standing
○Sneezing	○Lifting	○Walking
○Straining At Stool	○Bending	○Other
○Neck Movement	○Sitting	

9. If Your Complaints Include Pain, Is It Relieved By?

○Nothing	○Heat	○Sitting
○Rest	○Stretching	○Standing
○Ice	○Exercise	○Other

10. Have You Had Recent Treatment For This Condition?
○Yes ○No If Yes, List Dates, Treatments, And Doctors:

11. Has This Condition Existed In The Past? ○Yes ○No

12. Since Your Symptoms Began, Have You Noticed A Change In? If Yes, Indicate

	Onset Date	Duration
○Bowel Function		
○Bladder Function		
○Sexual Function		

C. REVIEW OF SYSTEMS

1. Are You Presently Suffering (Or Within The Past Six Months Suffered) From 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	○Convulsions
○Headache	○Nervousness
○Dizziness	○Other
○Fainting	

d. Eyes

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

e. Ears

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

f. Nose

○Normal	○Infections
○Pain	○Absence Of Smell
○Bleeding	○Other
○Sinus Problems	

g. Mouth/Throat

○Normal	○Absence Of Taste
○Sores	○Abnormal Taste
○Bleeding	○Tonsilitis
○Enlarged Glands	○Other

h. Cardio-Vascular-Pulmonary (Heart/Lungs)

○Normal	○Varicosities
○Cough	○Murmur
○Wheezing	○Chest Pain
○Difficulty Breathing	○Palpitations
○Swollen Extremities	○Other
○Blue Extremities	

i. Breasts

○Normal	○Dimpling
○Lumps In Breast(s)	○Discharge
○Redness/Itching	○Other
○Pain	

j. Gastrointestinal (Stomach/Digestion)

○Normal	○Excess Gas
○Decreased Appetite	○Vomiting
○Increased Appetite	○Diarrhea
○Abdominal Pain	○Constipation
○Hemorrhoids	○Other

k. Genitourinary

○Normal	○Painful Menstruation
○Inability To Hold Urine	○Abnormal Vaginal Bleeding
○Painful Urination	○Impotence
○Frequent Urination	○Sterility
○Bedwetting	○Prostate Problems
○Irregular Menstruation	○Other

l. Endocrine (Metabolism)

○Normal	○Goiter
○Heat/Cold Intolerance	○Tremor
○Sugar In Urine	○Other

m. Psychologic

○Normal	○Phobias
○Anxiety	○Mood Swings
○Depression	○Other
○Memory Loss Or Impairment	

C. REVIEW OF SYSTEMS (CONTINUED)

2. What Hobbies Do You Participate In?

List Hobbies:	Occasionally	Frequently	Constantly
1. _____	◯	◯	◯
2. _____	◯	◯	◯
3. _____	◯	◯	◯

3. What Are Your Habits?

	Never	<1	Packs/Day 1-2	2-3	3-4	5+
Smoking	◯	◯	◯	◯	◯	◯

	Never	<1	Drinks/Day 1-2	2-3	3-4	5+
Alcohol	◯	◯	◯	◯	◯	◯

	Never	<1	Cups-Glasses/Day 1-2	2-3	3-4	5+
Caffeinated Drinks	◯	◯	◯	◯	◯	◯

	Never	<1	Days/Week 1-2	3-4	5-6	7
Exercise	◯	◯	◯	◯	◯	◯

	Never	Yes	If Yes, Discuss With Doctor
Drug/Substance Abuse	◯	◯	

D. MEDICAL HISTORY

1. Health Care

a. Have You Been To A Chiropractor ..... Yes ◯ No ◯

b. Do You Have A Family Physician ..... Yes ◯ No ◯

Date Of Last Physical Exam _____

Physician's Name & Address _____

c. Have You Been Hospitalized In The Past Five Years ..... Yes ◯ No ◯

Date & Reason For Hospitalization _____

d. Have You Had Surgery In The Past Five Years ..... Yes ◯ No ◯

Date & Reason For Surgery _____

e. Have You Had A Serious Accident In The Past Five Years ..... Yes ◯ No ◯

◯Auto ◯Work ◯Home ◯Other _____

List Date & Describe Injury _____

f. Do You Have Any Drug Allergies ..... Yes ◯ No ◯

List Drugs _____

g. Are You Currently Taking Any Medication . Yes ◯ No ◯

◯Anti-inflammatory (Aspirin, Motrin, etc.)

◯Muscle Relaxants ◯Pain Medication/Analgesic

◯Tranquilizers ◯Antibiotics

◯Blood Pressure Pills ◯Other

◯Birth Control Pills _____

For What Condition/s Are You Taking Medication?

_____

h. WOMEN ONLY:

To Your Knowledge Are You Pregnant .... Yes ◯ No ◯

Have Your Past Pregnancies Been Normal . Yes ◯ No ◯

Are You Seeing An OB-GYN Regularly .... Yes ◯ No ◯

Date Of Last Exam _____

Physician's Name & Address _____

2. If you now have or you have had one of the following illnesses, please fill in EITHER bubble NH or bubble HH.

◯ *No Previous Conditions/Illnesses*

Now Have	Have Had		Now Have	Have Had	
◯	◯	Arthritis	◯	◯	Sexually Transmitted Disease
◯	◯	Asthma	◯	◯	Ulcer
◯	◯	Sinus Trouble	◯	◯	Cancer
◯	◯	Hay Fever	◯	◯	Polio
◯	◯	Allergies	◯	◯	Rheumatic Fever
◯	◯	Tuberculosis	◯	◯	Serious Injury
◯	◯	Diabetes	◯	◯	Bone Fracture
◯	◯	Epilepsy	◯	◯	Dislocated Joints
◯	◯	Thyroid Trouble	◯	◯	Spinal Disc Disease
◯	◯	High Blood Pressure	◯	◯	Multiple Sclerosis
◯	◯	Low Blood Pressure	◯	◯	Scoliosis
◯	◯	Heart Trouble	◯	◯	Mental/Emotional Difficulty
◯	◯	Pacemaker	◯	◯	Prostate Trouble
◯	◯	HIV/ARC	◯	◯	Kidney Trouble
◯	◯	AIDS	◯		Other _____
				◯	Other _____

3. Family History

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture	Present Age or Age at Death	Deceased
Father	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Mother	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D

E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Job Type

◯Full Time ◯Temporary

◯Part Time ◯Other _____

2. Work Week

Hours Per Day 1 2 3 4 5 6 7 8 9 10 11 12

Days Per Week 1 2 3 4 5 6 7

◯Other _____

3. Do Your Present Complaints Affect The Number Of Hours You Work Per Day ◯Yes ◯No

4. Length Of Time At Present Occupation

Years 10 20 30 40 50 / 1 2 3 4 5 6 7 8 9

Months 1 2 3 4 5 6 7 8 9 10 11

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E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING (CONTINUED)

5. Job Involves

a. **Lifting** . . . . . ○10 ○20 ○30 ○40 ○50 ○60 ○70 ○80 ○90 ○100+ Pounds

○Never ○Frequently

○Occasionally ○Constantly

b. **Additional Job Requirements**

○Bending ○Twisting ○Carrying

○Stooping ○Turning ○Walking

○Other

6. What Is Your Primary Work Position \ Location?

a. Position:

○Seated

○Standing

○Other

b. Location:

○Desk ○Counter

○Workbench

○Other

c. If Seated, What Type Of Chair Do You Use?

○Executive ○Steno ○Bench

○Stool ○Other

7. Do You Wear Shoes Or Boots With High Heels?

○Never ○Seldom ○Occasionally ○Frequently

8. Are You Right Or Left Handed?

○Right ○Left

9. Do Work Activities Aggravate Your Present Complaints?

○Yes ○No

10. Which Of The Following Best Describes Your Stress Level?

○None ○Minimal ○Moderate ○Great

11. How Do You Rate Your Physical Activity At Work?

○Seated more than 50% of workday

○Light Manual Labor

○Moderate Manual Labor

○Heavy Manual Labor

F. INSURANCE INFORMATION

1. Is Your Condition Due To:

	Yes	No
An Automobile Accident	○	○
A Personal Injury	○	○
A Job Injury	○	○

2. Do You Have Health Insurance . . . . . Yes ○ No ○

Company

Policy #

3. Is Your Spouse Employed. . . . . . Yes ○ No ○

Business

Address

4. Is Your Spouse The Primary Insured . . . . . Yes ○ No ○

Company

Policy #

5. HMO, PPO Plan Coverage . . . . . Yes ○ No ○

Company

Policy #

6. Are You Covered By Medicare . . . . . Yes ○ No ○

Medicare #

7. Authorization To Release Records To Patient's Insurance Carrier

Patient or Guardian's Signature

G. PAYMENT

IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.

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.

I WILL BE PAYING TODAY BY: (If paying by credit card please confirm which cards are accepted by our office.)

○Cash ○Check ○Visa

○MasterCard ○DiscoverCard ○American Express

○Other

Account #

Expiration Date

Patient's Signature Date

Guardian or Spouse's Signature Date

Doctor's Signature Date

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?

○Yes ○No

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