CHIROPRACTIC HEALTH QUESTIONNAIRE

To insure that we provide you with the best Chiropractic care possible, please take a few minutes to complete this form:

Patient Name: _____ Date: _____ / _____ / _____

If employed, what type of work do you do?: _____

Does it require any of the following activities: (check all that apply)

_Excessive lifting __ Bending __ Sitting __ Standing __ Walking __ Other

If other, please describe: _____

Have you ever been to a Chiropractor before?: __ If yes, whom did you see?_____

and for what reason: _____

Was your condition helped by Chiropractic Care?: _____

Are you taking any of the following types of medication: (check all that apply)

__ Muscle relaxers __ Pain killers __ Insulin __ Birth Control pills

__ Anti·inflammatory __ Over the counter meds (Tylenol, Advil, etc.)

__ Blood pressure med __ Other, please describe. _____

Have you had x·rays taken within the last year?: __ If yes, describe: _____

_____

Do you sleep on a regular mattress or a waterbed?: _____

Age of mattress or waterbed:_____ How many hours a night do you usually sleep: _____

Do you sleep on your __ back __ stomach __ side(s)

What kind of pillow do you use?: __ soft __ firm __ thin __ thick __ none

Do you sleep with more than one pillow?: _____ If yes, describe: _____

_____

Check all conditions that you have or have had in the past:

___ Anemia
___ Appendicitis
___ Arthritis
___ Bleeding disorders
___ Cancer
___ Cataracts
___ Chicken pox
___ Diabetes
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Hepatitis
___ High blood pressure
___ High Cholesterol
___ Kidney disease
___ Liver disease
___ Measles
___ Migraines
___ Miscarriage
___ Multiple sclerosis
___ Mumps
___ Osteoporosis
___ Polio
___ Prostate problems
___ Rheumatic fever
___ Scarlet fever
___ Thyroid
___ Tonsilitis
___ Tuberculosis
___ Tumors. growths
___ Typhoid fever
___ Ulcers
___ Whooping Cough

GENERAL SYMPTOMS: Check all that apply

___ Bruises easily
___ Chills
___ Dental problems
___ Depression
___ Difficulty sleeping
___ Dizziness
___ Fainting
___ Fever _Gas _Neck pain
___ Forgetfulness
___ Headaches
___ Loss of weight
___ Nervousness
___ Numbness
___ Sweats
___ Tiredness
___ Weight gain
___ Pain in arm(s)
___ Hand weakness
___ Low back pain
___ Back weakness
___ Knee pain
___ Weakness in leg

___ Poor appetite
___ Bloating
___ Bowel changes
___ Constipation
___ Diarrhea
___ Excessive hunger
___ Excessive thirst
___ Indigestion
___ Nausea
___ Rectal bleeding
___ Stomach pain
___ Chest pain
___ Poor circulation
___ Rapid heart beat
___ Blurred vision
___ Pain in elbow
___ Hands cold
___ Low back stiff
___ Hip pain
___ Ankle pain
___ Leg pain

___ Difficulty swallowing
___ Earache
___ Hay fever
___ Hearing loss
___ Nosebleeds
___ Persistent cough
___ Sinus problems
___ Neck stiffness
___ Pinched nerve in neck
___ Muscle spasms in neck
___ Head feels heavy
___ Grinding/popping sounds in neck
___ Shoulder pain
___ Mid-back pain
___ Pain between shoulder blades
___ Hand pain
___ Numbness in hand(s)
___ Spasms in back
___ Hip weakness
___ Foot pain
___ Leg cramps

Other symptoms not listed above: _____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date

Reviewed by: _____ _____
Signature Date