

# HEALTH QUESTIONNAIRE

Describe your main complaint: \_\_\_\_\_

Second Problem \_\_\_\_\_ Third Problem \_\_\_\_\_

Is this a new Problem? YES/NO If no when was the last episode of pain? \_\_\_\_\_

What was the initial cause that brought this on? \_\_\_\_\_

When did the problem come on? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

What is the quality of pain? Achy/Burning/Sharp/Throbbing/Numbness/Pins& Needles

Rate the pain out of 0-10 (Best 0,1,2,3,4,5,6,7,8,9,10 Worst)

Does it radiate any where YES/NO? Describe: \_\_\_\_\_

How long does it bother you? Constantly/Intermittent

Is it worst in Morning or Evening?

Have you seen a Chiropractor in the past? YES/NO

Is this related to a **car accident** or **workers compensation** injury? NO/YES

Have you consulted another doctor for your complaint? YES/NO Type of care? \_\_\_\_\_

List of Medications: \_\_\_\_\_

Nutritional Supplements: \_\_\_\_\_

Allergies to food or medications \_\_\_\_\_

List of past surgeries: \_\_\_\_\_

Occupation: \_\_\_\_\_ Description of daily tasks: \_\_\_\_\_

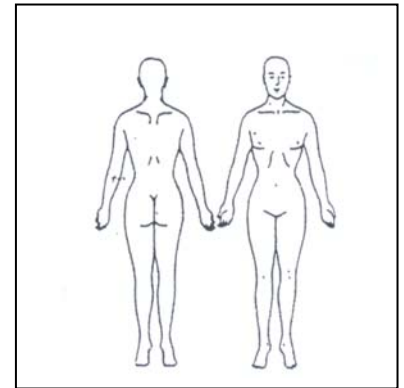
Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (Print) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

DOCTORS REMARKS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Health Questionnaire (Page 2)

In addition to helping you with your chief complaint, we have natural health care procedures that may help you with other health problems that you have. Check this list below and place an X next to the conditions that apply to you. You may write in any other condition that you want help with.

### Pain or Numbness

- Arthritis
- Bursitis
- Low back pain
- Disc problems
- Neck pain, stiffness
- Pain between shoulder blades
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tailbone
- Poor Posture
- Sciatica
- Spinal Curvature
- Swollen joints
- TMJ

### Respiratory

- Asthma
- Chest Pain
- Chronic Cough
- Difficult Breathing
- Spitting up phlegm
- Wheezing

### General

- Allergy
- Dizziness
- Fainting
- Fatigue
- Headache
- Loss of Sleep
- Nervousness
- Depression
- Numbness
- Sweats
- Tremors

### Gastro-Intestinal

- Belching or Gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult Digestion
- Bloating Abdomen
- Excessive Hunger
- Gallbladder Trouble
- Hemorrhoids
- Liver Trouble
- Nausea
- Pain over Stomach
- Poor Appetite
- Vomiting

### Cardio-vascular

- Hardening of Arteries
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Poor Circulation
- Rapid Heartbeat
- Slow Heartbeat
- Swelling of Ankles

### Eye, Ear, Nose, Throat

- Frequent Colds
- Deafness
- Earache
- Ear Discharge
- Ear Noise
- Enlarged Glands
- Enlarged Thyroid
- Eye Pain
- Failing Vision
- Gum Trouble
- Hay Fever
- Hoarseness
- Nasal Obstruction
- Nose Bleeds
- Freq Sinus Infection
- Freq. Sore Throat
- Freq. Tonsillitis

### Skin

- Boils

- Bruise Easily
- Dryness
- Hives/Allergy
- Itching
- Skin Rash
- Varicose Veins

### Genito/urinary

- Bed-Wetting
- Blood in Urine
- Freq. Urination
- Weak Bladder
- Kidney infection
- Painful urination
- Prostate Trouble

### Women Only

- Cramps/Backache
- Excess Flow
- Hot Flashes
- Irregular Cycle
- Lumps in Breast
- Menopause
- Painful Flow
- Vaginal Discharge

### Are you Pregnant? Y/N

How many weeks? \_\_\_\_\_  
Number of Pregnancies \_\_\_\_\_  
Number of Children \_\_\_\_\_

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### Check any of the following conditions you have or have had:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> AIDS             | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Pacemaker       | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Pleurisy        | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes (type ____) | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Polio           | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough _____ |

Thank you for your time in filling out this form. It helps us to better serve you.