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
01 02 03 04 05 06 07 08 09 10 11 12	01 02 03 04 05 06 07 08 09 10 20 30	00 01 10 20 30 40 50 60 70 80 90

DR# PATIENT NUMBER

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*

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

LEFT SIDE (P N T S S W S)		RIGHT SIDE (P N T S S W S)
	Head	
	Neck	
	Upper Back	
	Mid Back	
	Lower Back	
	Shoulder	
	Arm	
	Forearm	
	Wrist	
	Hand	
	Ribs	
	Buttock	
	Hip	
	Thigh	
	Leg	
	Knee	
	Ankle	
	Foot	

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)

NO MARKS HERE

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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 Currently Suffering From Any Of The Symptoms Listed Below?

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	

NO MARKS HERE

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C. REVIEW OF SYSTEMS (CONTINUED)

2. What Hobbies Do You Participate In?

List Hobbies:	Occasionally	Frequently	Constantly
1.	O	F	C
2.	O	F	C
3.	O	F	C

3. What Are Your Habits?

			Packs/Day			
Smoking	Never	<1	1-2	2-3	3-4	5+
			Drinks/Day			
Alcohol	Never	<1	1-2	2-3	3-4	5+
			Cups-Glasses/Day			
Caffeinated Drinks	Never	<1	1-2	2-3	3-4	5+
			Days/Week			
Exercise	Never	<1	1-2	3-4	5-6	7

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

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	
NH	HH	Arthritis	NH	HH	Sexually Transmitted Disease
NH	HH	Asthma	NH	HH	Ulcer
NH	HH	Sinus Trouble	NH	HH	Cancer
NH	HH	Hay Fever	NH	HH	Polio
NH	HH	Allergies	NH	HH	Rheumatic Fever
NH	HH	Tuberculosis	NH	HH	Serious Injury
NH	HH	Diabetes	NH	HH	Bone Fracture
NH	HH	Epilepsy	NH	HH	Dislocated Joints
NH	HH	Thyroid Trouble	NH	HH	Spinal Disc Disease
NH	HH	High Blood Pressure	NH	HH	Multiple Sclerosis
NH	HH	Low Blood Pressure	NH	HH	Scoliosis
NH	HH	Heart Trouble	NH	HH	Mental/Emotional Difficulty
NH	HH	Pacemaker	NH	HH	Prostate Trouble
NH	HH	HIV/ARC	NH	HH	Kidney Trouble
NH	HH	AIDS	NH		Other _____
				HH	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
- Part Time
- Temporary
- 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:**
   An Automobile Accident . . . . . Yes ○ No ○
   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

NO MARKS HERE NO MARKS HERE NO MARKS HERE

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PLEASE MAKE NO MARKS IN THIS AREA