

# 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 satisfactory, we will not accept your case. THANK YOU.

<b>Patient Name:</b>		<b>Date Of Birth:</b>	/ /
<b>Social Security #:</b>	- -	<b>Sex:</b>	<input type="radio"/> Male <input type="radio"/> Female
<b>Home Address:</b>		<b>Marital Status</b>	<b>Spouse Name</b>
		<input type="radio"/> Single <input type="radio"/> Divorced	
		<input type="radio"/> Widowed <input type="radio"/> Married	<b>Referred By</b>
		<input type="radio"/> Other	
<b>Home Phone:</b>	( )	<b>Mobile:</b>	( )
<b>Business Phone:</b>	( )	<b>E-Mail:</b>	
<b>Primary Care Physician</b>		<b>Telephone:</b>	( )

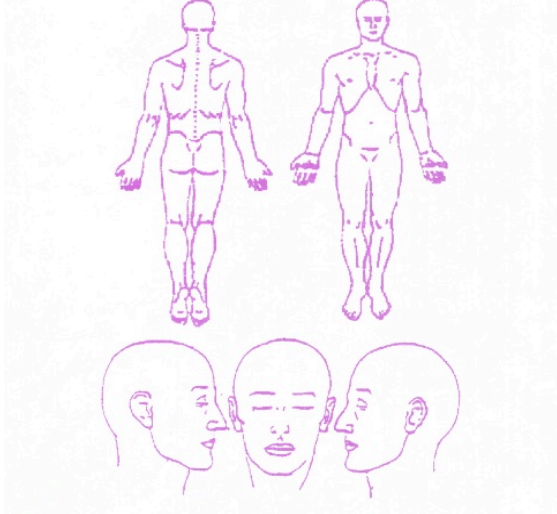
A: MAJOR COMPLAINTS	B: REVIEW OF SYSTEMS: Are you presently suffering (or within the past six months suffered) from any of the following?																																																																																																																																														
<p><b>1. What are your major complaints?</b>  <input type="radio"/> None</p> <table border="1" style="width:100%; border-collapse: collapse; text-align:center;"> <thead> <tr> <th></th> <th colspan="2">Pain</th> <th colspan="2">Numbness</th> <th colspan="2">Tingling</th> </tr> </thead> <tbody> <tr> <td>Head</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> </tr> <tr> <td>Neck</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> </tr> <tr> <td>Upper Back</td> <td>U</td> <td>U</td> <td>U</td> <td>U</td> <td>U</td> <td>U</td> </tr> <tr> <td>Mid Back</td> <td>M</td> <td>M</td> <td>M</td> <td>M</td> <td>M</td> <td>M</td> </tr> <tr> <td>Lower Back</td> <td>L</td> <td>L</td> <td>L</td> <td>L</td> <td>L</td> <td>L</td> </tr> <tr> <td></td> <td>R</td> <td>L</td> <td>R</td> <td>L</td> <td>R</td> <td>L</td> </tr> <tr> <td>Shoulder</td> <td>S</td> <td>S</td> <td>S</td> <td>S</td> <td>S</td> <td>S</td> </tr> <tr> <td>Arm</td> <td>A</td> <td>A</td> <td>A</td> <td>A</td> <td>A</td> <td>A</td> </tr> <tr> <td>Forearm</td> <td>F</td> <td>F</td> <td>F</td> <td>F</td> <td>F</td> <td>F</td> </tr> <tr> <td>Hand</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> </tr> <tr> <td>Buttock</td> <td>B</td> <td>B</td> <td>B</td> <td>B</td> <td>B</td> <td>B</td> </tr> <tr> <td>Hip</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> <td>H</td> </tr> <tr> <td>Thigh</td> <td>T</td> <td>T</td> <td>T</td> <td>T</td> <td>T</td> <td>T</td> </tr> <tr> <td>Leg</td> <td>L</td> <td>L</td> <td>L</td> <td>L</td> <td>L</td> <td>L</td> </tr> <tr> <td>Foot</td> <td>F</td> <td>F</td> <td>F</td> <td>F</td> <td>F</td> <td>F</td> </tr> </tbody> </table> <p><b>2. Currently your pain is aggravated by</b></p> <p><input type="radio"/> Coughing</p> <p><input type="radio"/> Lifting</p> <p><input type="radio"/> Sneezing</p> <p><input type="radio"/> Bending</p> <p><input type="radio"/> Straining At Stool</p> <p><input type="radio"/> Sitting</p> <p><input type="radio"/> Neck Movement</p> <p><input type="radio"/> Standing</p> <p><input type="radio"/> Reaching</p> <p><input type="radio"/> Walking</p> <p><input type="radio"/> Other: _____</p> <p><b>3. Since your symptoms began, have you notice a change in</b></p> <p><input type="radio"/> Bowel Function</p> <p><input type="radio"/> Bladder Function</p> <p><input type="radio"/> Ability To Maintain An Erection</p>		Pain		Numbness		Tingling		Head	H	H	H	H	H	H	Neck	N	N	N	N	N	N	Upper Back	U	U	U	U	U	U	Mid Back	M	M	M	M	M	M	Lower Back	L	L	L	L	L	L		R	L	R	L	R	L	Shoulder	S	S	S	S	S	S	Arm	A	A	A	A	A	A	Forearm	F	F	F	F	F	F	Hand	H	H	H	H	H	H	Buttock	B	B	B	B	B	B	Hip	H	H	H	H	H	H	Thigh	T	T	T	T	T	T	Leg	L	L	L	L	L	L	Foot	F	F	F	F	F	F	<p><b>1. a. General</b></p> <p><input type="radio"/> Normal <input type="radio"/> Chills</p> <p><input type="radio"/> Fatigue <input type="radio"/> Weight Change</p> <p><input type="radio"/> Weakness <input type="radio"/> Night Sweats</p> <p><input type="radio"/> Fever</p> <p><input type="radio"/> Other: _____</p> <p><b>b. Skin</b></p> <p><input type="radio"/> Normal <input type="radio"/> Eczema</p> <p><input type="radio"/> Rash <input type="radio"/> Hair Changes</p> <p><input type="radio"/> Redness <input type="radio"/> Nail Changes</p> <p><input type="radio"/> Itching</p> <p><input type="radio"/> Other: _____</p> <p><b>c. Neurologic</b></p> <p><input type="radio"/> Normal <input type="radio"/> Fainting</p> <p><input type="radio"/> Headache <input type="radio"/> Convulsions</p> <p><input type="radio"/> Dizziness</p> <p><input type="radio"/> Other: _____</p> <p><b>d. Eyes</b></p> <table style="width:100%;"> <tr> <td><input type="radio"/> Normal</td> <td style="text-align:right;">Right</td> <td style="text-align:right;">Left</td> </tr> <tr> <td>Vision Trouble</td> <td style="text-align:center;"><input type="radio"/></td> <td style="text-align:center;"><input type="radio"/></td> </tr> <tr> <td>Pain</td> <td style="text-align:center;"><input type="radio"/></td> <td style="text-align:center;"><input type="radio"/></td> </tr> <tr> <td>Discharge</td> <td style="text-align:center;"><input type="radio"/></td> <td style="text-align:center;"><input type="radio"/></td> </tr> <tr> <td>Other: _____</td> <td></td> <td></td> </tr> </table> <p><b>e. 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Mouth/Throat</b></p> <p><input type="radio"/> Normal <input type="radio"/> Absence Of Taste</p> <p><input type="radio"/> Sores <input type="radio"/> Abnormal Taste</p> <p><input type="radio"/> Bleeding</p> <p><input type="radio"/> Other: _____</p> <p><b>h. Heart/Lungs</b></p> <p><input type="radio"/> Normal <input type="radio"/> Blue Extremities</p> <p><input type="radio"/> Cough <input type="radio"/> Murmur</p> <p><input type="radio"/> Wheezing <input type="radio"/> Chest Pain</p> <p><input type="radio"/> Difficulty Breathing <input type="radio"/> Palpitations</p> <p><input type="radio"/> Swollen Extremities</p> <p><input type="radio"/> Other: _____</p> <p><b>i. Breasts</b></p> <p><input type="radio"/> Normal <input type="radio"/> Dimpling</p> <p><input type="radio"/> Lumps In Breast(s) <input type="radio"/> Discharge</p> <p><input type="radio"/> Redness/Itching <input type="radio"/> Pain</p> <p><input type="radio"/> Other: _____</p> <p><b>j. Stomach/Intestines</b></p> <p><input type="radio"/> Normal <input type="radio"/> Vomiting</p> <p><input type="radio"/> Decreased Appetite <input type="radio"/> Diarrhea</p> <p><input type="radio"/> Increased Appetite <input type="radio"/> Constipation</p> <p><input type="radio"/> Abdominal Pain</p> <p><input type="radio"/> Other: _____</p> <p><b>k. Reproductive/Urination</b></p> <p><input type="radio"/> Normal <input type="radio"/> Impotence</p> <p><input type="radio"/> Inability To Hold Urine <input type="radio"/> Sterility</p> <p><input type="radio"/> Painful Urination</p> <p><input type="radio"/> Frequent Urination</p> <p><input type="radio"/> Irregular Menstruation</p> <p><input type="radio"/> Abnormal Vaginal Bleeding</p> <p><input type="radio"/> Painful Menstruation</p> <p><input type="radio"/> Other: _____</p> <p><b>l. Glandular</b></p> <p><input type="radio"/> Normal <input type="radio"/> Goiter</p> <p><input type="radio"/> Heat/Cold Intolerance <input type="radio"/> Tremor</p> <p><input type="radio"/> Sugar In Urine</p> <p><input type="radio"/> Other: _____</p> <p><b>m. Mental</b></p> <p><input type="radio"/> Normal <input type="radio"/> Phobias</p> <p><input type="radio"/> Anxiety <input type="radio"/> Mood Swings</p> <p><input type="radio"/> Depression</p> <p><input type="radio"/> Memory Loss or Impairment</p> <p><input type="radio"/> Other: _____</p>	<input type="radio"/> Normal	Right	Left	Vision Trouble	<input type="radio"/>	<input type="radio"/>	Pain	<input type="radio"/>	<input type="radio"/>	Discharge	<input type="radio"/>	<input type="radio"/>	Other: _____			<input type="radio"/> Normal	Right	Left	Hearing Trouble	<input type="radio"/>	<input type="radio"/>	Ringing	<input type="radio"/>	<input type="radio"/>	Discharge	<input type="radio"/>	<input type="radio"/>	Other: _____		
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## 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)

## 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. Woman:<br>To the best of your knowledge are you pregnant? | (Y) | (N) |
| Are you under regular care of an OB-GYN?.....                | (Y) | (N) |
| d. Have you been hospitalized in the past five(5) years?     | (Y) | (N) |
| e. Are you currently taking any medication?.....             | (Y) | (N) |
- Anti-inflammatory (Aspirin, Motrin, etc.)  
 Muscle Relaxants       Birth Control Pills  
 Tranquilizers       Pain Medication/Analgesic  
 Other: \_\_\_\_\_

### 2. Which of the following illnesses have you had?

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

## 3. FAMILY HISTORY

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

## 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 Name: _____		
Policy/I.D. #: _____		
4. Are you covered by Medicare?.....	(Y)	(N)
Medicare I.D. #: _____		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself (the patient). 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 to 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: \_\_\_\_\_ Card Security ID #: \_\_\_\_\_

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

Patient's Signature

Date



Guardian or Spouse's Signature

Date