

# HEALTH QUESTIONNAIRE

—PLEASE PRINT—

TO SAVE TIME AND TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS

NAME		REFERRED BY	
COMPLETE ADDRESS		DOB	AGE
HOME PHONE	WORK PHONE	CELL PHONE	
EMAIL		BEST WAY TO CONTACT YOU	BEST TIME
<input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED	NO. OF CHILDREN	NAMES/AGES OF CHILDREN	
OCCUPATION	EMPLOYER	EMPLOYER ADDRESS	
PLEASE INDICATE IF YOU ARE HERE FOR CARE BECAUSE OF: <input type="checkbox"/> ON THE JOB INJURY <input type="checkbox"/> AUTO INJURY <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER			
PLEASE EXPLAIN:			
SOCIAL SECURITY NUMBER	HAVE YOU HAD CHIROPRACTIC CARE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE? _____ WHEN? _____		
WHAT BRINGS YOU IN TODAY?	HOW LONG HAS IT BEEN BOTHERING YOU?	HAS IT BOTHERED YOU BEFORE?	
DO YOU HAVE HEALTH INSURANCE? <input type="checkbox"/> YES, COMPANY <input type="checkbox"/> NO	ARE YOU ON MEDICARE? <input type="checkbox"/> YES, # _____ <input type="checkbox"/> NO	ARE YOU ON MEDICAID? <input type="checkbox"/> YES, # _____ <input type="checkbox"/> NO	
ARE YOU ON A REIMBURSING INSURANCE? <input type="checkbox"/> YES, COMPANY <input type="checkbox"/> NO	SPOUSE'S NAME & INSURANCE		
SPOUSE'S DATE OF BIRTH	SPOUSE'S SOCIAL SECURITY NUMBER		
HAVE YOU EVER HAD ANY FALLS, AUTO ACCIDENTS OR INJURIES? <input type="checkbox"/> YES, PLEASE EXPLAIN <input type="checkbox"/> NO	PLEASE PROVIDE MO/YR, TYPE OF ACCIDENT AND DESCRIBE INJURY.		
HAVE YOU EVER HAD SURGERY? <input type="checkbox"/> YES, PLEASE EXPLAIN <input type="checkbox"/> NO	PLEASE PROVIDE MO/YR, TYPE OF SURGERY AND ANY OTHER COMMENTS.		
ARE YOU PRESENTLY TAKING ANY MEDS OR VITAMINS? <input type="checkbox"/> YES, PLEASE EXPLAIN <input type="checkbox"/> NO	PLEASE PROVIDE THE NAME, DOSAGE & DURATION FOR EACH.		
LIST ANY SPORTS/EXERCISE PROGRAMS	DO YOU DRINK ALCOHOL? _____ AMT/WK _____ DO YOU SMOKE? _____ PACKS PER DAY _____		

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

— PLEASE SEE OTHER SIDE —

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY OR YOU HAVE HAD RECENTLY.

<input type="checkbox"/> HEADACHES 784.0	<input type="checkbox"/> FAINTING 780.2	<input type="checkbox"/> SHORTNESS OF BREATH 786.09	<input type="checkbox"/> ULCERS 534.9
<input type="checkbox"/> SHOOTING HEAD PAINS 784.0	<input type="checkbox"/> LOSS OF BALANCE 781.2	<input type="checkbox"/> MID-BACK PAIN 724.1	<input type="checkbox"/> NUMBNESS OF LEGS/FEET 782.0
<input type="checkbox"/> SINUS TROUBLE 473.9	<input type="checkbox"/> RINGING IN EARS 388.3	<input type="checkbox"/> HEART ATTACK 410.9	<input type="checkbox"/> CONSTIPATION 564.0
<input type="checkbox"/> LOSS OF SMELL 781.1	<input type="checkbox"/> BLURRED VISION 368.0	<input type="checkbox"/> HIGH BLOOD PRESSURE 401.9	<input type="checkbox"/> KIDNEY TROUBLE 593.9
<input type="checkbox"/> ALLERGIES 995.3	<input type="checkbox"/> LIGHTS HURT EYES 368.13	<input type="checkbox"/> LOW BLOOD PRESSURE 458.9	<input type="checkbox"/> MENSTRUAL CRAMP/PAIN 625.3
<input type="checkbox"/> HAYFEVER 477.8	<input type="checkbox"/> NECK PAIN 723.1	<input type="checkbox"/> ANEMIA 285.9	<input type="checkbox"/> MENSTRUAL IRREG. 626.4
<input type="checkbox"/> ASTHMA 493.9	<input type="checkbox"/> MUSCLE SPASM NECK 781.0	<input type="checkbox"/> STOMACH TROUBLE 789.0	<input type="checkbox"/> DIABETES 250.0
<input type="checkbox"/> LOSS OF TASTE 781.1	<input type="checkbox"/> GRINDING IN NECK 719.68	<input type="checkbox"/> NERVES/NERVOUSNESS 799.2	<input type="checkbox"/> SLEEPING PROBLEMS 780.5
<input type="checkbox"/> INFLAM. OF THROAT 462.0	<input type="checkbox"/> TIGHT SHOULDER & ARM 728.85	<input type="checkbox"/> INNER TENSION 799.2	<input type="checkbox"/> PAINFUL JOINTS 719.4
<input type="checkbox"/> THYROID TROUBLE 246.9	<input type="checkbox"/> PAIN IN SHOULDER/ARM 719.4	<input type="checkbox"/> IRRITABILITY 799.2	<input type="checkbox"/> SWOLLEN JOINTS 719.0
<input type="checkbox"/> FACE TWITCH 351.9	<input type="checkbox"/> PINS/NEEDLES IN ARMS/HANDS 782.0	<input type="checkbox"/> GALL BLADDER TROUBLE 575.9	<input type="checkbox"/> PINS/NEEDLES IN LEG 782.0
<input type="checkbox"/> FATIGUE 780.7	<input type="checkbox"/> COLD HANDS 782.0	<input type="checkbox"/> INDIGESTION 536.8	<input type="checkbox"/> SWOLLEN ANKLES 782.3
<input type="checkbox"/> DEPRESSION 311.0	<input type="checkbox"/> NUMBNESS IN ARM/HAND 782.0	<input type="checkbox"/> INTESTINAL GAS 787.3	<input type="checkbox"/> COLD FEET 782.0
<input type="checkbox"/> DIZZINESS 780.4	<input type="checkbox"/> COLD HAND/FINGERS 782.0	<input type="checkbox"/> LOW BACK PAIN 724.2	<input type="checkbox"/> PAIN IN LEG/FEET 719.46
<input type="checkbox"/> SPINAL CURVATURE 737.43	<input type="checkbox"/> TONSILITIS 784.0	<input type="checkbox"/> HERNIA 550.01	<input type="checkbox"/> HIP PAIN 719.45
<input type="checkbox"/> CHEST PAIN 786.5	<input type="checkbox"/> PROSTATE TROUBLE 601.4	<input type="checkbox"/> STROKE 436.0	
		<input type="checkbox"/> BED WETTING 788.3	

### FAMILY HISTORY SECTION

DO ANY OF YOUR CHILDREN HAVE ANY OF THE FOLLOWING?		DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING? IF YES WHAT RELATION TO YOU-	
	NAME & AGE		
HEADACHES	YES/NO _____	DIABETES	YES/NO _____
ALLERGIES	YES/NO _____	CANCER	YES/NO _____
EAR INFECTIONS	YES/NO _____	STROKE	YES/NO _____
FREQUENT COLDS	YES/NO _____	HEART PROBLEMS	YES/NO _____
ASTHMA	YES/NO _____	SCOLIOSIS	YES/NO _____
CONSTANT IRRITABILITY	YES/NO _____	BACK PROBLEMS	YES/NO _____
CONSTIPATION	YES/NO _____	HEADACHES	YES/NO _____
GROWING PAINS	YES/NO _____	ULCERS	YES/NO _____
HYPERTENSIVE	YES/NO _____		
BLOODY NOSES	YES/NO _____		
SCOLIOSIS	YES/NO _____		
BEDWETTING	YES/NO _____		

HAVE ALL YOUR CHILDREN HAD A SCOLIOSIS EXAM BY A CHIROPRACTOR? **YES/NO**

HAVE ANY OF YOUR RELATIVES BEEN EXAMINED BY A CHIROPRACTOR? **YES/NO**

DO ANY OF THE PEOPLE YOU WORK WITH HAVE THE SAME HEALTH PROBLEMS AS YOU? **YES/NO** IF YES, PLEASE EXPLAIN- \_\_\_\_\_

TO THE BEST OF YOUR KNOWLEDGE, ARE YOU PREGNANT, EITHER SUSPECTED OR CONFIRMED AT THIS PARTICULAR TIME? **YES/NO**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

HEIGHT \_\_\_\_\_ ' \_\_\_\_\_ "      WEIGHT \_\_\_\_\_ LBS

BLOOD PRESSURE- LEFT \_\_\_\_\_ / \_\_\_\_\_

BLOOD PRESSURE- RIGHT \_\_\_\_\_ / \_\_\_\_\_

PULSE (L) \_\_\_\_\_ (R) \_\_\_\_\_