

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	DR#	PATIENT NUMBER																			
1	1	1																					
2	2	2																					
3	3	3																					
4	4	4																					
5	5	5																					
6	6	6																					
7	7	7																					
8	8	8																					
9	9	9																					

Date Of Birth
Social Security #

Sex:
 Male
 Female

Marital Status:
 Single
 Married
 Widowed
 Divorced
 Other _____

Patient Resides With:
 Lives Alone Spouse Parents
 Children Other _____

Children: 0 1 2 3 4 5+

Patient's Home Address

Phone **FAX**

Employer Business Address

Phone
Occupation

Referred By

Spouse Name
Social Security #

A. MAJOR COMPLAINTS

1. What are your major complaints?

	Pain		Numbness		Tingling	
	R	L	R	L	R	L
None						
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)
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)

2. Currently your pain is aggravated by

- Coughing Lifting
- Sneezing Bending
- Straining At Stool Sitting
- Neck Movement Standing
- Reaching Walking
- Other _____

3. Since your symptoms began, have you noticed a change in

- Bowel Function Bladder Function
- Ability To Maintain An Erection

B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

- 1. a. GENERAL**
- Normal Chills
 - Fatigue Weight Change
 - Weakness Night Sweats
 - Fever Other _____

- b. SKIN**
- Normal Eczema
 - Rash Hair Changes
 - Redness Nail Changes
 - Itching Other _____

- c. NEUROLOGIC**
- Normal Fainting
 - Headache Convulsions
 - Dizziness Other _____

- d. EYES**
- | | | |
|------------------------------|-----------------------|-----------------------|
| <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"/> | <input type="radio"/> |

- e. EARS**
- | | | |
|------------------------------|-----------------------|-----------------------|
| <input type="radio"/> Normal | Right | Left |
| Hearing Trouble | <input type="radio"/> | <input type="radio"/> |
| Ringing | <input type="radio"/> | <input type="radio"/> |
| Pain | <input type="radio"/> | <input type="radio"/> |
| Discharge | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

- f. NOSE**
- Normal
 - Pain Absence Of Smell
 - Bleeding Other _____

- g. MOUTH/THROAT**
- Normal
 - Sores Absence Of Taste
 - Bleeding Abnormal Taste
 - Other _____

- h. HEART/LUNGS**
- Normal Blue Extremities
 - Cough Murmur
 - Wheezing Chest Pain
 - Difficulty Breathing Palpitations
 - Swollen Extremities Other _____

- i. BREASTS**
- Normal Dimpling
 - Lumps In Breast(s) Discharge
 - Redness/Itching Other _____
 - Pain

- j. STOMACH/INTESTINES**
- Normal Vomiting
 - Decreased Appetite Diarrhea
 - Increased Appetite Constipation
 - Abdominal Pain Other _____

- k. REPRODUCTIVE/URINATION**
- Normal Impotence
 - Inability To Hold Urine Sterility
 - Painful Urination Other _____
 - Frequent Urination
 - Irregular Menstruation
 - Painful Menstruation
 - Abnormal Vaginal Bleeding

- l. GLANDULAR**
- Normal Goiter
 - Heat/Cold Intolerance Tremor
 - Sugar In Urine Other _____

- m. MENTAL**
- Normal
 - Anxiety Phobias
 - Depression Mood Swings
 - Memory Loss or Impairment Other _____

2. What are your habits?

- Smoking
- Alcohol
- Recreational Drugs
- Exercise

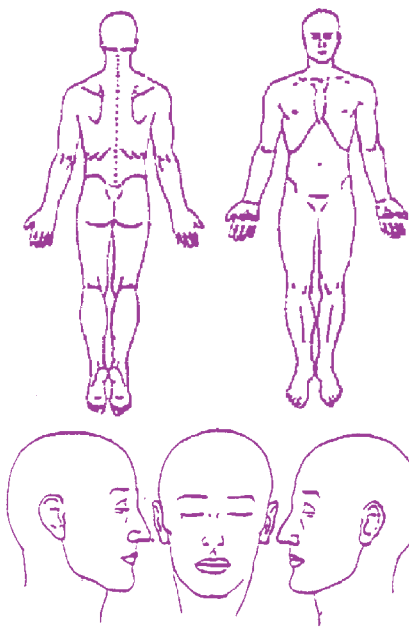
	Never	Occasionally	Moderately	Excessively
Smoking	(S)	(S)	(S)	(S)
Alcohol	(A)	(A)	(A)	(A)
Recreational Drugs	(R)	(R)	(R)	(R)
Exercise	(E)	(E)	(E)	(E)

3. FAMILY HISTORY

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

C. PAIN DIAGRAMMS

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

2. Which of the following illnesses have you had?

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

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 _____ | | |
| Policy # _____ | | |
| 4. Are you covered by Medicare | (Y) | (N) |
| Medicare # _____ | | |

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.

F. PAYMENT

I WILL BE PAYING TODAY BY:

- Cash Check Credit Card
- MasterCard Visa American Express
- Account # _____ Exp. Date _____

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

Patient's Signature	Date
_____	_____
Guardian or Spouse's Signature	Date
_____	_____
Doctor's Signature	Date
_____	_____

NO MARKS HERE NO MARKS HERE NO MARKS HERE