HEALTH QUESTIONNAIRE

○ Initial ○ Re-Eval

Patient Name: _____

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭ **Erase** changes cleanly. Do **not fold** form.

MO	DAY	YEAR	DR#	PATIENT NUMBER
○1 ○7	○1	○0	○0 ○0	○0 ○0 ○0 ○0 ○0 ○0 ○0 ○0 ○0 ○0
○2 ○8	○2	○10 ○1	○1 ○1 ○1	○1 ○1 ○1 ○1 ○1 ○1 ○1 ○1 ○1 ○1
○3 ○9	○3	○20 ○2	○2 ○2 ○2	○2 ○2 ○2 ○2 ○2 ○2 ○2 ○2 ○2 ○2
○4 ○10	○4	○30 ○3	○3 ○3 ○3	○3 ○3 ○3 ○3 ○3 ○3 ○3 ○3 ○3 ○3
○5 ○11	○5	○40 ○4	○4 ○4 ○4	○4 ○4 ○4 ○4 ○4 ○4 ○4 ○4 ○4 ○4
○6 ○12	○6	○50 ○5	○5 ○5 ○5	○5 ○5 ○5 ○5 ○5 ○5 ○5 ○5 ○5 ○5
	○10 ○7	○60 ○6	○6 ○6 ○6	○6 ○6 ○6 ○6 ○6 ○6 ○6 ○6 ○6 ○6
	○20 ○8	○70 ○7	○7 ○7 ○7	○7 ○7 ○7 ○7 ○7 ○7 ○7 ○7 ○7 ○7
	○30 ○9	○80 ○8	○8 ○8 ○8	○8 ○8 ○8 ○8 ○8 ○8 ○8 ○8 ○8 ○8
		○90 ○9	○9 ○9 ○9	○9 ○9 ○9 ○9 ○9 ○9 ○9 ○9 ○9 ○9

A. PATIENT INFORMATION

Marital Status:
○ Single
○ Married
○ Separated
○ Divorced
○ Widowed

Sex:
○ M ○ F

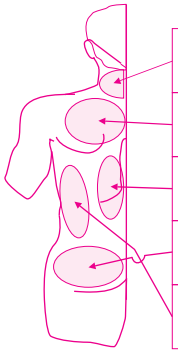
Children:
0 1 2 3 4 5+
○ ○ ○ ○ ○ ○

Patient Lives With:
○ Alone ○ Parents
○ Spouse ○ Roomate(s)
○ Children ○ Assisted Living
○ Other

B. PATIENT'S COMPLAINTS

1. Mark Your Present Complaints Below ○ Physical Examination with no complaints.

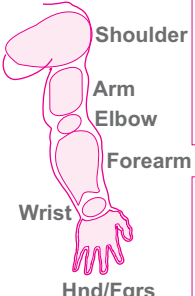
Neck / Back



		Same As Left	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Neck	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Upr Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Mid Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Low Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Ribs	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Neck/Back Complaints Begin?
○ Date: / /

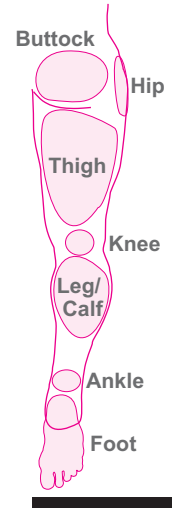
Upper Extremities



		Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Shoulder		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Arm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
RIGHT	Shoulder		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Arm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Upper Extremity Complaints Begin?
○ Same Date As Neck/Back
○ Different Date: / /

Lower Extremities



		Hip	Buttock	Thigh	Knee	Leg/Calf	Ankle	Foot
LEFT			S	S	S	S	S	S
RIGHT			S	S	S	S	S	S

		Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Hip	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Buttock	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Foot	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
RIGHT	Hip	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Buttock	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Foot	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Lower Extremity Complaints Begin?
○ Same Date As Neck/Back
○ Different Date: / /

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PLEASE MAKE NO MARKS IN THIS AREA

B. PATIENT'S COMPLAINTS (CONTINUED)

2. How Did Your Complaint(s) Begin[1]?
○Unknown ○Suddenly ○Gradually

3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?
○Cause Not Known ○Auto Accident
○Work Accident/Injury ○Home Accident
○Personal Injury ○Sport Injury
○Other - Describe:_____

4. How Would You Rate Your Overall Pain Today Where 0 Is No Pain And 10 Is The Worst Pain[1]?
No Pain ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 Worst Pain Possible

5. When Are Your Symptoms Worse?
○Morning ○Afternoon ○Evening ○Night
○Always The Same

6. What Makes Your Condition Better?
○Nothing ○Stretching ○Heat
○Rest ○Exercise ○Ice
○Sitting ○Standing ○Medications
○Other_____

7. What Makes Your Condition Worse?
○Nothing ○Coughing ○Reaching ○Standing
○Sneezing ○Lifting ○Sitting ○Pulling
○Bending ○Walking ○Straining at Stool ○Turning
○Other_____

8. Have Any Of Your Complaint(s) Existed In The Past? ○Yes ○No
If Yes, Indicate Below
○Neck ○Upr Back ○Mid Back ○Low Back ○Ribs
○Shoulder ○Arm ○Elbow ○Forearm ○Wrist ○Hnd/fgrs
○Buttock ○Hip ○Thigh ○Knee ○Leg/calf ○Ankle ○Foot
○Others:_____

9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office[1]?
○Yes ○No If Yes, List Dates, Treatments, And Doctors.

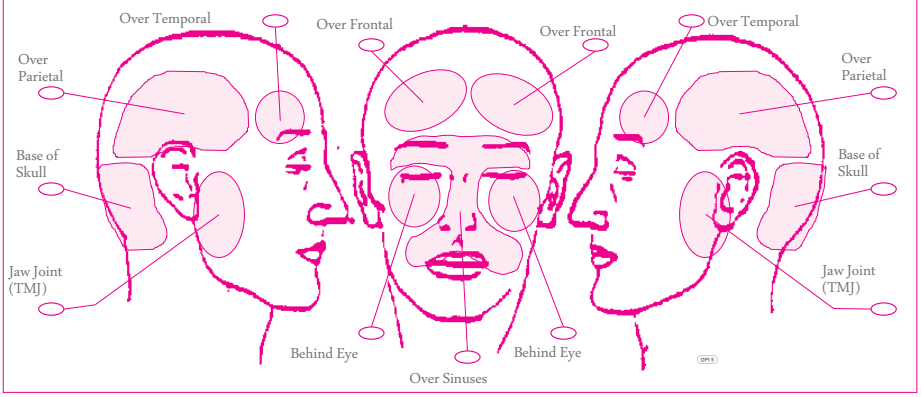
10. Since Your Symptoms Began, Have You Noticed A Change In?

Bowel Function	○Yes	○No	○No To All
Bladder Function	○Yes	○No	
Sexual Function	○Yes	○No	

C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.

1. Where is The Pain Associated With Your Headaches Located?



2. On What Date Did Your Headaches Begin[1]?
○Date: __/__/__ ○Same As Neck/Back Complaints

3. How Does The Intensity Of Your Headaches Rate[1]?
No Pain ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 Worst Pain Possible

4. What Describes Your Pain?
○Dull ○Sharp ○Aching ○Stabbing
○Deep ○Vice-Like ○Burning ○Throbbing/Pulsating
○Other_____

5. When Do Your Headaches Usually Start?
○Constant/Anytime Awake ○Wake Up With In Morning
○At Midday ○During Evening

6. What Seems To Bring On Your Headaches?
○Physical Activity ○Caffeine
○Excessive Stress ○Certain Foods
○Alcohol ○Menstrual Period
○Other_____

7. How Often Do They Occur[1]?
Times/Week: ①②③④⑤⑥⑦⑧⑨
Times/Month: ①②③④⑤⑥⑦⑧⑨
○Other_____

8. How Long Do Your Headaches Last[1]?
○Less Than 1 Hour ○From 1-3 Hours
○Longer Than 3 Hours ○All Waking Hours
○Several Hours To Days
○Other_____

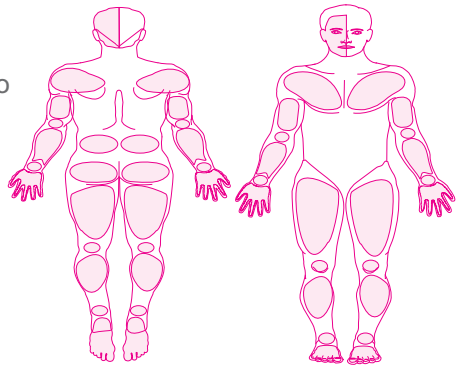
9. Do Your Headaches Wake You From Sleep[1]?
○No ○Sometimes ○Always

10. Do Any Of The Following Occur With Your Headaches?
○Nausea/Vomiting ○Weakness
○Tremor ○Vision Problems
○Dizziness ○Light/Sound Sensitivity
○Other_____

11. What Makes Your Headaches Better?
○Nothing ○NSAIDS (Aspirin, Tylenol, etc.) ○Rest
○Massage ○Lying Down ○Standing ○Ice/Cold Packs
○Other_____

D. OTHER COMPLAINTS

Do you have any other complaints not covered on this form[1]? ○Yes ○No
If Yes, Describe other complaints in detail and mark body areas on Figures. →



HEALTH QUESTIONNAIRE-HISTORY

Patient's Name

E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

○ **None** Of The Symptoms Listed Below	○ **No New** Symptoms Since Your Last Exam

- ○ General Fatigue
- ○ Weakness
- ○ Fever (continuous)
- ○ Loss Of Sleep
- ○ Chills (continuous)
- ○ Weight Change (unplanned)
- ○ Night Sweats

- ○ Headaches
- ○ Dizziness
- ○ Fainting
- ○ Convulsions
- ○ Nervousness

- ○ Anxiety
- ○ Depression (prolonged)
- ○ Phobias (excessive fears)
- ○ Memory Loss Or Impairment
- ○ Mood Swings (excessive)

	Left	Right
Hearing Trouble	○	○
Ringing in Ears	○	○
Pain in Ears	○	○
Ear Discharge	○	○
Vision Trouble	○	○
Pain in Eyes	○	○
Eye Discharge	○	○

- ○ Nose/Sinus Pain
- ○ Excessive Drainage
- ○ Nose Bleeds (chronic)
- ○ Nasal Infections (chronic)
- ○ Absence Of Smell

- ○ Mouth Sores
- ○ Bleeding Gums
- ○ Enlarged Glands
- ○ Absence Of Taste
- ○ Abnormal Taste Sensation
- ○ Tonsillitis/Infected Tonsils
- ○ Difficulty With Swallowing

- ○ Heat/Cold Intolerance
- ○ Sugar In Urine
- ○ Goiter (enlargedThyroid gland)
- ○ Tremor (shaking)

- ○ Skin Rash
- ○ Redness Of Skin
- ○ Skin Itching
- ○ Skin Dryness
- ○ Eczema(red, inflamed skin)
- ○ Hair Changes (unplanned)
- ○ Nail Changes (unplanned)
- ○ Bruise Easily

- ○ Cough (chronic)
- ○ Wheezing (chronic)
- ○ Difficulty Breathing
- ○ Swollen Extremities
- ○ Blue Extremities
- ○ Varicosities (visible veins)
- ○ Rapid Heart Beat
- ○ Chest Pain
- ○ Heart Palpitations
- ○ Heart Murmur

- ○ Decreased Appetite
- ○ Increased Appetite
- ○ Abdominal Pain
- ○ Hemorrhoids
- ○ Excess Gas
- ○ Vomiting (excessive)
- ○ Diarrhea (excessive)
- ○ Constipation (excessive)
- ○ Heartburn/Indigestion

- ○ Painful Urination
- ○ Inability To Hold Urine
- ○ Frequent Urination
- ○ Urinary Retention
- ○ Bed-wetting
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding
- ○ Sterility
- ○ Impotence

- ○ Lumps In Breast(s)
- ○ Redness/Itching of Breast
- ○ Dimpling of Breast(s)
- ○ Discharge from Breast(s)
- ○ Breast Pain

○ Other (Please Describe)

F. HABITS/ACTIVITIES

What Are Your Habits?

	Never	None	Packs Per Day <1	1-2	2-3	3-4	5+
Smoking	○	○	○	○	○	○	○

	Never	None	Glasses Per Day <1	1-2	2-3	3-4	5+
Caffeinated Drinks	○	○	○	○	○	○	○
Alcohol Consumption	○	○	○	○	○	○	○

Drug/Substance Abuse.. ○ No ○ Yes **If Yes, Discuss With Doctor**

	Never	Days Per Week <1	1-2	2-3	3-4	5+
Exercise	○	○	○	○	○	○

Kinds Of Exercise You Do:

○ Walking ○ Jogging ○ Cycling ○ Swimming
○ Golf ○ Tennis ○ Strength Training
○ Other: _____

G. MEDICAL HISTORY

1.HEALTH CARE

a. Have You Ever Been To A Chiropractor? . . . . ○ Yes ○ No

b. Do You Have A Family Physician . . . . . ○ Yes ○ No

Date Of Last Physical Exam: _____
Physician's Name: _____
Address: _____
Phone:( )

c. Have You Been Hospitalized In The Past? . . . ○ Yes ○ No

Date & Reason For Hospitalization: _____

d. Have You Ever Had Surgery? . . . . . ○ Yes ○ No

Date, Reason, Results Of Surgery: _____

e. Have You Ever Had A Serious Accident/Injury? ○ Yes ○ No

List Date & Describe Injury:

○ Auto: _____
○ Work-Related: _____
○ Personal: _____
○ Sports Injury: _____
○ Other: _____

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements) ○ Yes ○ No

_____

g. Are You Currently Taking Any Medications? ○ Yes ○ No

For What Condition(s) Are You Taking Medication?

○ Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.): _____
○ Pain/Analgesics: _____
○ Anti-Depressants: _____
○ Muscle Relaxants: _____
○ Blood Pressure Pills: _____
○ Antibiotics: _____
○ Birth Control Pills: _____
○ Corticosteroid: _____
○ Other: _____

In The Past Have You Use Any Of The Following?

○ Birth Control Pills ○ Corticosteroid

h. Are You Allergic To Any Medications? . . . . . ○ Yes ○ No

List Medications: _____

G. MEDICAL HISTORY - CONTINUED

1i. WOMEN ONLY:

	Yes	No
To Your Knowledge, Are You Pregnant?	○	○
If Pregnant In Past, Were Pregnancies Normal?	○	○
Are You Seeing An OB-GYN Regularly?	○	○

Number Of Births: ① ② ③ ④ ⑤ ○ Other:___

Date Of Last Exam:_____

Physician's Name:_____

Address:_____

_____ Phone:( )_____

2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased?
Father	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	D
Mother	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	D
Brothers	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	
Sisters	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	
Children	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	

Describe Others:_____

3. Conditions Or Illnesses

Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:

○ ***No Current Or Previous Conditions/Illnesses***

Now Have	In Past		Now Have	In Past	
H	P	Sinus Trouble	H	P	Kidney Trouble
H	P	Hay Fever	H	P	Urinary Retention
H	P	Allergies	H	P	Frequent Urination
H	P	Asthma	H	P	Prostate Trouble
H	P	Emphysema	H	P	Arthritis
H	P	Tuberculosis	H	P	Osteoporosis
H	P	History of Infection	H	P	Scoliosis
H	P	Fever (Continuous)	H	P	Dislocated Joints
H	P	Cancer/Tumor	H	P	Spinal Disc Disease
H	P	Diabetes	H	P	Bone Fracture (list/dates):
H	P	Visual Disturbances			
H	P	Dizziness/Fainting			
H	P	Epilepsy/Seizures			
H	P	Thyroid Trouble	H	P	Mental/Emotional Difficulty
H	P	High Blood Pressure	H	P	Sex. Trans. Diseases
H	P	Low Blood Pressure	H	P	HIV
H	P	Heart Trouble	H	P	AIDS/ARC
H	P	Pacemaker	H	P	Abnormal Weight Gain
H	P	Stroke [date_____]	H	P	Abnormal Weight Loss
H	P	Aortic Aneurysm	H	P	Numbness Groin/Buttocks
H	P	Anemia	H		Other:
H	P	Rheumatic Fever			
H	P	Polio			
H	P	Multiple Sclerosis		P	Other:
H	P	Ulcer			
H	P	Liver Trouble			

H. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Are You Right Or Left Handed? ○ Right ○ Left

2. Job Type

○ Retired ○ Unemployed ○ Full-Time Student

If Any Of Above Skip Rest, Sign At Patient's Signature

○ Full Time ○ Part Time ○ Temporary

○ Self-Employed ○ Other

3. During Your Work Week, You Work How Many:

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

4. How Long Have You Been With Your Present Employer?

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

5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day? ○ Yes ○ No

6. What Is Your Primary Work Position and Location?

a. Work Position: ○ Seated ○ Standing ○ Other

b. Work Location: ○ Desk ○ Counter ○ Workbench ○ Other

7. What Movements Does Your Job Require?

○ Bending ○ Turning ○ Stooping
○ Twisting ○ Walking ○ Repetitive Hand Use
○ Carrying ○ Other

8. Does Your Work Include Any Of The Following Use?

○ Prolonged Computer ○ Continuous Phone

9. Does Your Job Involve Lifting?

○ Never ○ Occasionally ○ Intermittently
○ Frequently ○ Constantly

How Many Pounds? (Choose Only One) ○10 ○20 ○30 ○40 ○50 ○60 ○70 ○80 ○90 ○100+ Pounds

10. What Best Describes Your Stress Level At Work?

○ None ○ Minimal ○ Minimal To Moderate
○ Moderate ○ Moderate To Extreme ○ Extreme

11. How Do You Rate Your Physical Activity At Work?

○ Seated more than 50% of workday

Manual Labor: ○ Light ○ Light To Moderate ○ Moderate ○ Moderate To Heavy ○ Heavy

12. Do Work Activities Aggravate Your Present Complaints?

○ Yes ○ No **If Yes, Explain:** _____

PATIENT'S SIGNATURE **DATE:**

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PLEASE MAKE NO MARKS IN THIS AREA