HEALTH HISTORY QUESTIONNAIRE

GCC
GOOING CHIROPRACTIC CLINIC
(714) 556-9188
3151 AIRWAY AVE., SUITE P2
COSTA MESA, CA 92626

This is a comprehensive review of your full history. Please include conditions that are no longer an issue. It is important to fill out all of the information requested. Your history may indicate risks and adverse side effects in association with alternative health care.

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed, including cancer.

Your Height: **Weight:** **Blood Pressure: (if known)**

Has your weight changed significantly in the last 12 months? ☐ Yes ☐ No

All Surgeries (include Dental Surgeries)

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

X-rays

	Dates and Reason
Spinal	
MRI	
CT	
Mammograms	
Dental	
Other	

Gooing Chiropractic Clinic
Health History page 2

Patient Name_____

Adverse Reaction to any of following	
	Reaction You Had
Physical Therapy	
Nutritional Therapy	
Chiropractic Care	
Have you ever rejected a Doctors prescription for care?	Why?

List your prescribed drugs and over-the-counter drugs, such as vitamins, aspirin, allergy meds and inhalers

Name the Drug or Nutritional product	Dosage or Strength	Frequency Taken

List allergies to medications. Include prescription and over the counter.

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					

Continued on next page

Gooing Chiropractic Clinic

Health History page 3

Patient Name_____

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks/day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	Do you use hormone replacement therapy?				☐ Yes	☐ No
	Do you have a Sexually transmitted disease?				☐ Yes	☐ No
	Are you a sexual abuse victim?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have memory loss? If yes. short term or long term?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
Have you had any significant or severe emotional traumas?	☐ Yes	☐ No
Have you been diagnosed with any mental illnesses?	☐ Yes	☐ No
Other issues not mentioned? Please explain.	☐ Yes	☐ No

Gooing Chiropractic Clinic
Health History page 4

Patient Name_____

HEAD AND FACIAL CONDITIONS		
Do you experience headache? If so, list what type.	☐ Yes	☐ No
Do you have Trigeminal neuralgia?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you have facial pain or numbness?	☐ Yes	☐ No
Do you have TMJ?	☐ Yes	☐ No
Do you have clicking in your jaw?	☐ Yes	☐ No
Do you have lockjaw?	☐ Yes	☐ No
Do you have difficulty chewing?	☐ Yes	☐ No
Do you have a history of concussions?	☐ Yes	☐ No

WOMEN ONLY		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Have you had a colonoscopy? If yes, when?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, what times _____		
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Have you had a prostate and rectal exam? If yes, when.	☐ Yes	☐ No
Have you had a colonoscopy? If yes, when?	☐ Yes	☐ No

I have completed the above health history completely to the best of my knowledge.

Name:_____ Date:_____

Signature:_____