File # ____
Date: ___/___/_____

Health Questionnaire

1. Patient Information

First Name: ____________________ **Middle Name:** ______________ **Last Name:** ________________

Address: ____

City: ____________________________________ **State:** ___________ **Zip Code:** __________________

Cell Phone: _______________________________ **Cell Phone Carrier:** __________________________

Email: ________________________________ I authorize my doctor to contact me via Text and Email

How did you find our office? ____

Date of Birth: ___/____/_______ **Age:** ____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Unspecified**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** **Spouse Name:** ____________

Employment Status: ☐ **Employed** ☐ **Student** ☐ **Retired**

Emergency Contact Information: **Full Name:** ___________________ **Relationship:** ______________

Phone Number: __________________________

2. Smoking History

Do you currently smoke tobacco of any kind?
☐ **Yes** ☐ **Former smoker** ☐ **Never**

If yes, how often do you smoke?
☐ **Daily**
☐ **Occasionally**

If yes, what is your interest in quitting?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5

No interest Very interested

3. Allergies

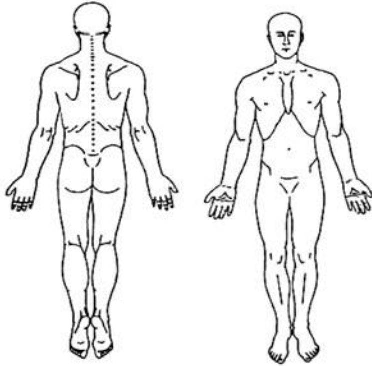
Are you allergic to any medications?
☐ **Yes** ☐ **No**

If yes, which medications?

____

Are you allergic to any of the following:
☐ **Bee Sting** ☐ **Latex** ☐ **Peanuts**
☐ **Shellfish** ☐ **Dairy** ☐ **Mold**
☐ **Pollen** ☐ **Wheat** ☐ **Eggs** ☐ **Nuts**
☐ **Other:** ___________________________

4. Patient Condition



What is the main reason for consulting our office?

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce Symptoms
- ☐ Resume normal activity level

Please answer the following questions for EACH SEPARATE AREA of pain you are experiencing:

What is your major complaint: ____

Is this condition due to an accident? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other Date: _______

How did this problem begin (falling, lifting, etc.) ________________________________?

How is your condition changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Have you had this condition in the past? ☐ Yes ☐ No

Are your symptoms on one side more than the other? ☐ Right ☐ Left ☐ Central ☐ Both

What is the intensity of your pain at present? ☐ None ☐ Mild ☐ Moderate ☐ Severe

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ___ Sharp ___ Dull ___ Numb ___ Burning
___ Shooting ___ Tingling ___ Stabbing ___ Tightness ___ Stiffness ___ Throbbing

Does your pain Radiate? ☐ Yes ☐ No *If yes, Where?* ______________________________

Please rate your pain on a scale of 0-10 (0 is no pain and 10 is excruciating pain)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition: ☐ Working ☐ Exercise ☐ Driving ☐ Sleeping ☐ Rest
☐ Other: ____

What activities make your pain better: ☐ Ice ☐ Heat ☐ Massage ☐ Stretching ☐ Rest
☐ Other: ____

What is your SECOND complaint: ____

Is this condition due to an accident? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other **Date:** _______

How did this problem begin (falling, lifting, etc.) ______________________________?

How is your condition changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Have you had this condition in the past? ☐ Yes ☐ No

Are your symptoms on one side more than the other? ☐ Right ☐ Left ☐ Central ☐ Both

What is the intensity of your pain at present? ☐ None ☐ Mild ☐ Moderate ☐ Severe

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Aching
☐ Shooting ☐ Tingling ☐ Stabbing ☐ Tightness ☐ Stiffness ☐ Throbbing

Does your pain Radiate? ☐ Yes ☐ No ***If yes, Where?*** ______________________________

Please rate your pain on a scale of 0-10 (0 is no pain and 10 is excruciating pain)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition: ☐ Working ☐ Exercise ☐ Driving ☐ Sleeping ☐ Rest
☐ Other: ____

What activities make your pain better: ☐ Ice ☐ Heat ☐ Massage ☐ Stretching ☐ Rest
☐ Other: ____

5. Medications

If there are no current medications, Check here: ☐

	Medication Name	Dosage (1 tab/ 5g)	Frequency (2x/day)	Start Date
1				
2				
3				
4				
5				
6				

6. Social History

Work Activity: What is your job description: ____

What do you do most of the day at work? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor
☐ Other: ____

How would you describe the physical stress level at work? ☐ Low ☐ Medium ☐ High

Diet/ Nutrition:

Alcohol Use: ☐ Yes ☐ No Amount/ Weekly: ___________

Caffeine Use: ☐ Yes ☐ No Amount/ Weekly: ___________

Have you gained or lost over 10 pounds in the past 6 months without wanting to? ☐ Yes ☐ No

7. Personal Health History

Are you currently under the care of a Healthcare Provider or any other doctor? ☐ Yes ☐ No

Provider Name: ______________________ Facility Name: ____________________________________

Have you ever had chiropractic care? ☐ Yes ☐ No
Last visit: _________ Were X-rays taken? ☐ Yes ☐ No

Has any doctor diagnosed you with Hypertension recently? ☐ Yes ☐ No

Has any doctor diagnosed you with Diabetes recently? ☐ Yes ☐ No

Surgeries:

	Date	**Procedure** (i.e. knee repair)
1		
2		
3		
4		
5		
6		

8. Review of Systems

Please indicate if you have any of the following by checking the box.

Constitutional	☐ None ☐ chills	☐ fever ☐ fatigue	☐ daytime drowsiness ☐ loss of appetite	☐ night sweats ☐ weight loss/ gain
Muskulo-skeletal	☐ None ☐ Leg pain ☐ Stiff joints	☐ Neck pain ☐ Arm pain ☐ Spasm	☐ Low back pain ☐ Swollen joints ☐ Pain between shoulder	☐ Mid back pain ☐ Painful joints ☐ Sore muscles
Eyes/Vision	☐ None ☐ tearing	☐ itching ☐ spots	☐ double vision ☐ blind spots	☐ cataracts ☐ wears contacts/ glasses
Ears, Nose, & Throat	☐ None ☐ dizziness ☐ headaches ☐ nosebleeds	☐ fainting ☐ nosebleeds ☐ ear pain ☐ hearing loss	☐ runny nose ☐ frequent sore throats ☐ loss of sense of smell	☐ history of head injury ☐ runny nose ☐ sinus infections
Respiration	☐ None ☐ wheezing	☐ cough ☐ asthma	☐ shortness of breath ☐ coughing up blood	☐ coughing up blood ☐ sputum production
Cardiovascular	☐ None ☐ murmurs	☐ palpitations ☐ ulcers	☐ high blood pressure ☐ shortness of breath	☐ varicose veins ☐ claudication (leg pain)
Gastrointestinal	☐ None ☐ ulcers ☐ diarrhea ☐ indigestion	☐ belching ☐ constipation ☐ heartburn ☐ diarrhea	☐ difficulty swallowing ☐ abdominal pain ☐ abnormal stool ☐ loss of bowel control	☐ jaundice ☐ black/ tarry stool ☐ rectal bleeding
Female	☐ None ☐ cramps I… ☐ am currently pregnant I… ☐ am NOT currently pregnant	☐ birth control ☐ irregular menstruation	☐ frequent urination	☐ vaginal discharge
Male	☐ None ☐ erectile dysfunction	☐ inconstinence	☐ burning urination	☐ frequent urination
Skin	☐ None ☐ hives ☐ itching	☐ hair loss ☐ skin lesions ☐ numbness	☐ change in skin color ☐ skin disorder ☐ hair loss	☐ change in nail texture ☐ varicosities
Nervous System	☐ None ☐ stroke ☐ stress ☐ numbness	☐ seizures ☐ dizziness ☐ headaches	☐ limb weakness ☐ sleep disturbance ☐ loss of consciousness	☐ loss of balance ☐ slurred speech ☐ loss of memory
Psychological	☐ None ☐ anxiety ☐ confusion	☐ depression ☐ convulsions ☐ behavorial changes	☐ bi-polar disorder ☐ loss/change of appetite	☐ mood change ☐ insomnia
Hematologic	☐ None ☐ fatgiue	☐ bleeding ☐ anemia	☐ blood transfusion ☐ blood clotting	☐ bruising easily ☐ lymph node swelling

9. Family History

Relation	Age (now/at death)			Serious illness/cause of death
Father		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Paternal grandfather		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Paternal grandmother		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Mother		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Maternal grandfather		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Maternal grandmother		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Brother(s)		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Sister(s)		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Sons(s)		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	
Daughter(s)		☐ Alive ☐ Deceased	☐ no significant disease ☐ has/had: ___________	

All of the answers I have given are correct to best of my knowledge, and I agree to continue with Chiropractic evaluation at Essential Family Chiropractic.

____ _____________________

Patient Signature or Signature of Parent or Legal Guardian **Date**