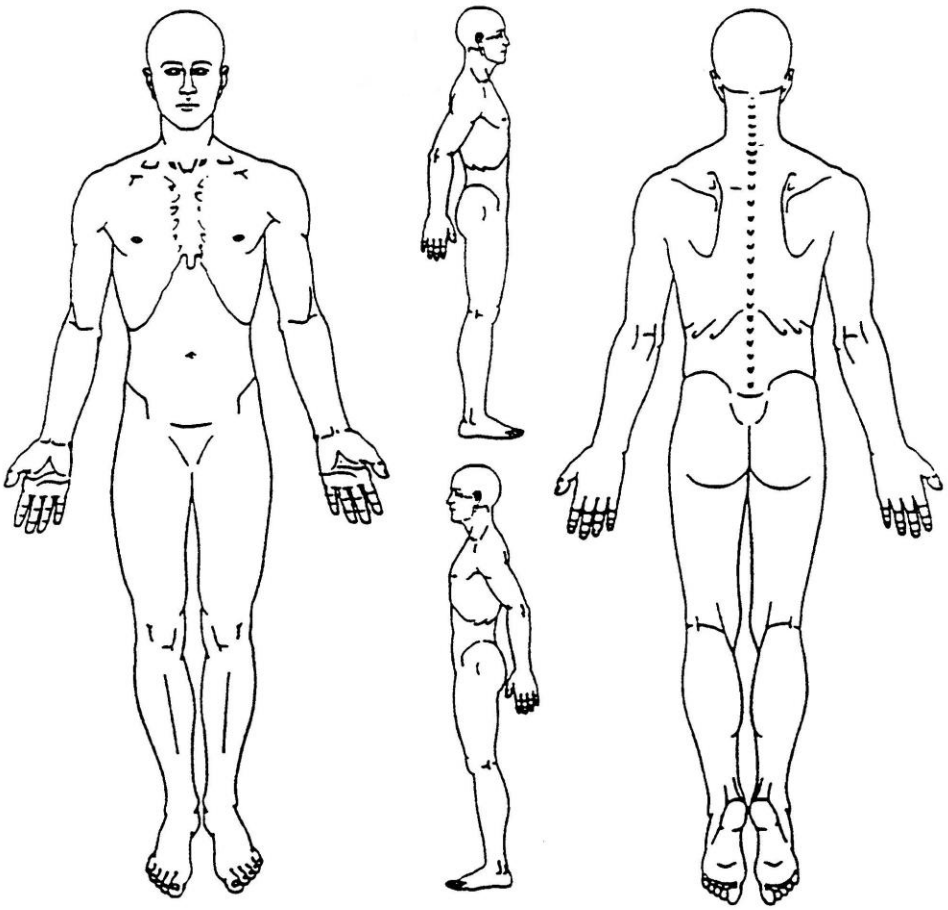
Patient Name: _____ **Date** __ /___ /___

HEALTH QUESTIONNAIRE

A. Major Complaints

1. What are your major complaints? _____
2. How long have you had the pain? _____ years _____ months _____weeks _____days
3. How did your symptoms begin? _____
4. Your pain is aggravated by: ☐ Lifting/Bending ☐ Standing ☐ Activity ☐ Driving/Sitting
   ☐ Walking ☐ Rest ☐ Other_____
5. What makes your pain feel better? ☐ Rest ☐ Activity ☐ Analgesic Medications
   ☐ Nothing ☐ Other_____
6. Do work activities aggravate your present complaints? Yes No

On the diagram below, please indicate where you are experiencing pain or other symptoms.
Please choose the letter (A, B, N, P, S or O) that corresponds to the type of pain and write it on the area of the body below.



A = ACHE

B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER

B. Review of Systems

Are you presently suffering (or have suffered in the past six months) from any of the following symptoms? Please check normal if there are no symptoms.

EYES:			**EARS:**			**NOSE:**	**MOUTH/THROAT:**
☐ **Normal**	**R**	**L**	☐ **Normal**	**R**	**L**	☐ **Normal**	☐ **Normal**
Vision Trouble	☐	☐	☐Hearing Trouble	☐	☐	☐ Pain	☐ Sores
Pain	☐	☐				☐ Bleeding	☐ Dryness
Discharge	☐	☐	☐Ringing	☐	☐	☐ Absence of smell	☐ Other_____
☐ Other: _____			☐Pain	☐	☐	☐ Other_____	
			☐ Other_____				
SKIN:			**HEART:**			**LUNGS:**	**GLANDULAR/ENDOCRINE**
☐ **Normal**			☐ **Normal**			☐ **Normal**	☐ **Normal**
☐Rash			☐ Murmur			☐ Cough	☐ Hot/Cold Intolerance
☐ Itching			☐ Chest Pain			☐ Wheezing	☐ Sugar in urine
☐ Eczema			☐ Palpitations			☐ Difficulty Breathing	☐ Goiter
☐ Hair changes			☐ Swollen Extremities			☐ Blue Extremities	☐Tremor
☐ Nail changes			☐ Other_____			☐ Other_____	☐ Other_____
☐ Other_____							

MENTAL/NEUROLOGIC:	**STOMACH/INTESTINES:**	**REPRODUCTIVE/URINATION:**
☐ **Normal**	☐ **Normal**	☐ **Normal**
☐ Anxiety	☐Decreased Appetite	☐ Inability to hold urine
☐ Depression	☐ Increased Appetite	☐ Painful Urination
☐ Memory loss or impairment	☐ Abdominal	☐ Frequent Urination
☐ Phobias	☐ Vomiting	☐ Irregular Menstruation
☐ Mood Swings	☐ Diarrhea	☐ Painful Menstruation
☐ Headache	☐ Constipation	☐ Abnormal Vaginal Bleeding
☐ Dizziness	☐ Other_____	☐ Impotence
☐ Convulsions		☐ Sterility
☐ Other_____		☐ Other_____

2. What Are Your Habits? (Please circle)

Smoking: ☐ Never a smoker ☐ Former smoker ☐ Current Smoker (circle one) Heavy or Light

Alcohol: ☐ Abstains ☐ Former ☐ Current (circle one) Social/Light/Medium/Heavy ☐ Alcoholic

Drug/Substance Use: ☐ Never ☐ Occasionally ☐ Moderately ☐ Excessive

Caffeine: ☐ Doesn't drink caffeine ☐ 1 cup a day ☐ 2-4 cups a day ☐ 5+ cups a day

Diet: ☐ Healthy ☐ Needs Improvement ☐ Poor

Exercise: Days Per Week 0 <1 1-2 2-3 3-4 5+

Kinds of Exercise You Do: ☐ Walking ☐ Cycling ☐ Jogging ☐ Swimming ☐ Strength Training ☐ Other_____

C. Medical History

1. Health Care: (Please Circle)

Have you been to a chiropractor? Yes No
Have you been hospitalized in the last 5 years? Yes No
Have you ever had Surgery? Yes No If hysterectomy, partial or complete? _____
Please list the dates and reasons of any prior surgeries

_____

_____

Are you currently taking any medications? Yes No
If yes please list the name and dosage of medications or attach a copy of your medications:

_____

_____

Are you allergic to any medications? Yes No
If yes, please list them: _____

Women: Are you pregnant? Yes No If yes, How many weeks? _____
Are you under the care of an OB-GYN? Yes No

2. Which of the following illnesses have you had?

☐ No Previous Illness	☐ Thyroid problems	☐ Polio	☐ Scoliosis
☐ Arthritis	☐ High Blood pressure	☐ Rheumatic Fever	☐ Prostate Trouble
☐ Asthma	☐ Low Blood Pressure	☐ Bone Fracture	☐ Mental Difficulties
☐ Sinus Trouble	☐ Heart Trouble	☐ Spinal Disc Disease	☐ Ulcer
☐ Allergies	☐ HIV/ARC	☐ Multiple Sclerosis	☐ Epilepsy
☐ Tuberculosis	☐ AIDS	☐ Kidney Trouble	☐ Diabetes Type 1 or 2

☐ Cancer (Type & Years) _____ ☐ Other _____
(circle one) Chemo Radiation None

3. Family Health History: (Please check all that apply)

Father: ☐ Diabetes ☐ Cardiovascular disease ☐ High Blood Pressure ☐ Stroke ☐ Headaches ☐ Neck/Back problems
☐ Arthritis ☐ Osteoporosis ☐ Cancer: Type _____ ☐Other_____

Mother: ☐ Diabetes ☐ Cardiovascular disease ☐ High Blood Pressure ☐ Stroke ☐ Headaches ☐ Neck/Back problems
☐ Arthritis ☐ Osteoporosis ☐ Cancer: Type _____ ☐ Other_____

Siblings: ☐ Diabetes ☐ Cardiovascular disease ☐ High Blood Pressure ☐ Stroke ☐ Headaches ☐ Neck/Back problems
☐ Arthritis ☐ Osteoporosis ☐ Cancer: Type _____ ☐ Other_____

Children: ☐ Diabetes ☐ Cardiovascular disease ☐ High Blood Pressure ☐ Stroke ☐ Headaches☐ Neck/Back problems
☐ Arthritis ☐ Osteoporosis ☐ Cancer: Type _____ ☐ Other_____

D. Occupational History

1. **Job Type:** Retired Full time Student Unemployed Full time Part time Temporary Self-Employed
2. **What movements does your job require?** ☐ Bending ☐ Light to moderate lifting ☐ Stooping ☐ Walking ☐ Moderate to heavy lifting ☐ Turning ☐ Repetitive Hand use ☐ Other _____
3. **What is your primary position at work?** ☐ Sitting ☐ Standing ☐ Other _____
4. **Do work activities aggravate your present complaints?** Yes No
5. **Patient/Guardian Signature: _____ Date: _____**