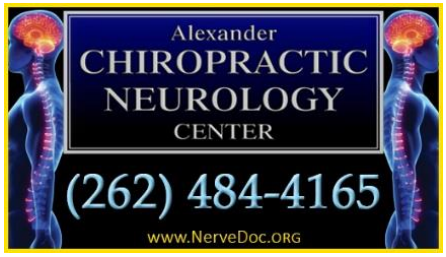

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THANK YOU FOR YOUR TRUST!

HEALTH QUESTIONNAIRE

WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY? _____

_____

_____

PLEASE DESCRIBE: SHARP- ☐ DULL - ☐ ACHE- ☐ WEAKNESS- ☐ THROBBING- ☐ NUMBNESS- ☐ TINGLING- ☐ SHOOTING- ☐ BURNING- ☐

FREQUENCY OF OCCURRENCE: INTERMITTENT (1-25%)- ☐ OCCASIONAL (26-50%)- ☐ FREQUENT (51-75%)- ☐ CONSTANT (76-100%)- ☐

WHAT IS THE INTENSITY OF YOU PAIN AT ITS LOWEST & HIGHEST LEVEL: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (MOST PAIN)

ARE YOUR SYMPTOMS: DECREASING- ☐ NOT CHANGING - ☐ GETTING WORSE- ☐

SYMPTOMS ARE WORSE: UPON WAKING- ☐ EARLY MORNING- ☐ LATE MORNING- ☐ AFTERNOON- ☐ AFTER WORK- ☐ AT BEDTIME- ☐

DOES THE DISCOMFORT/PAIN RADIATE/TRAVEL TO OTHER AREAS OF THE BODY? _____

_____

DESCRIBE HOW THE PROBLEM BEGAN: _____

_____

HAVE YOU BEEN TREATED FOR THIS BEFORE? YES- ☐ NO- ☐

IF (YES), BY WHOM? CHIROPRACTOR- ☐ MEDICAL DOCTOR- ☐ PHYSICAL THERAPIST- ☐ MASSAGE THERAPIST- ☐ OTHER- _____

ARE YOU CURRENTLY BEING SEEN? YES- ☐ NO- ☐ IF SO, HOW OFTEN AND WHAT TREATMENTS? _____

WHAT MAKES YOUR DISCOMFORT BETTER? NOTHING- ☐ LYING DOWN- ☐ WALKING- ☐ STANDING- ☐ SITTING- ☐ MOVEMENT/EXERCISE- ☐ INACTIVITY- ☐

OTHER- _____

WHAT MAKES YOUR DISCOMFORT WORSE? NOTHING- ☐ LYING DOWN- ☐ WALKING- ☐ STANDING- ☐ SITTING- ☐ MOVEMENT/EXERCISE- ☐ INACTIVITY- ☐

OTHER- _____

HOW WOULD YOU RATE YOUR STRESS LEVEL? LITTLE / NO STRESS- ☐ MINIMAL STRESS- ☐ MODERATE STRESS- ☐ GREAT STRESS- ☐

GENERAL PHYSICAL ACTIVITY: NO REGULAR EXERCISE- ☐ LIGHT EXERCISE- ☐ MODERATE EXERCISE- ☐ STRENUOUS EXERCISE- ☐

DOES YOUR DISCOMFORT, DYSFUNCTION OR PAIN AFFECT YOUR ABILITY TO BE ACTIVE? (CHECK THE APPROPRIATE ONE)

1.) ☐ -NO EFFECT
2.) ☐ -ABLE TO PERFORM LIGHT DUTY WORK AND HOUSEHOLD TASKS
3.) ☐ -NEED LIMITED ASSISTANCE TO PERFORM TASKS
4.) ☐ -NEED ASSISTANCE OFTEN
5.) ☐ -HAVE SIGNIFICANT INABILITY TO FUNCTION WITHOUT ASSISTANCE
6.) ☐ -I AM TOTALLY DISABLED (IMPAIRED)

PHYSICAL ACTIVITY AT WORK: SITTING 50% OR MORE OF WORKDAY- ☐ LIGHT MANUAL LABOR- ☐ MANUAL LABOR- ☐ HEAVY MANUAL LABOR- ☐

HAS YOUR WORK STATUS CHANGED BECAUSE OF THIS COMPLAINT? YES- ☐ NO- ☐

WHAT IS YOUR CURRENT WORK STATUS?

1.) ☐ -FULL-TIME / NO RESTRICTIONS
2.) ☐ -PART-TIME / NO RESTRICTIONS
3.) ☐ -FULL-TIME W/ RESTRICTIONS
4.) ☐ -PART-TIME W/ RESTRICTIONS
5.) ☐ -OFF WORK DUE TO RESTRICTIONS
6.) ☐ -FULL-TIME HOMEMAKER
7.) ☐ -RETIRED
8.) ☐ -FULL-TIME STUDENT

DO YOU HAVE A PERMANENT DISABILITY? LOCATION- _____ RATING PERCENTAGE- _____ % DATE RECEIVED- _____

PRESENT PERSONAL INFORMATION:

Note: all information obtained herein is a confidential record of your history; and will not be released to anyone without your prior consent. As your doctor it is important for us to know this information so we may provide you with the best possible care.

HEIGHT: _____ FT. _____ IN. WEIGHT: _____ LBS. BLOOD PRESSURE: _____ / _____ PULSE RATE: _____ /MIN

PETS: DOG(S)- ☐ CAT(S)- ☐ BIRD(S)- ☐ FISH- ☐ OTHER- _____

TOBACCO USE:	NEVER- ☐	INFREQUENT ½ PACK / WEEK- ☐	MODERATE 1 PACK / WEEK- ☐	HEAVY 2+ PACKS / WEEK- ☐
ALCOHOL USE:	NEVER- ☐	INFREQUENT 1 - 2 / WEEK- ☐	MODERATE 3 – 5 / WEEK- ☐	HEAVY 6+ / WEEK- ☐
CAFFEINE USE:	NEVER- ☐	INFREQUENT 1 - 2 / WEEK- ☐	MODERATE 3 – 5 / WEEK- ☐	HEAVY 6+ / WEEK- ☐
RECREATIONAL DRUGS:	NEVER- ☐	INFREQUENT 1 – 2 TIMES / WEEK- ☐	MODERATE 3 – 5 TIMES / WEEK- ☐	HEAVY 6+ TIMES / WEEK- ☐

DRUGS / MEDICATIONS: _____

_____

_____

DO YOU CURRENTLY HAVE? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL:
- ☐ CANCER
- ☐ FATIGUE / CHRONIC FATIGUE
- ☐ FEVER
- ☐ WEIGHT GAIN >10LBS.
- ☐ WEIGHT LOSS >10LBS.

SKIN:
- ☐ NAIL CHANGES
- ☐ NEW LESIONS
- ☐ RASH
- ☐ SKIN COLOR CHANGES

HEENT:
- ☐ DECREASED HEARING
- ☐ DOUBLE VISION
- ☐ DRY MOUTH
- ☐ EAR RINGING
- ☐ EYE PAIN
- ☐ EYE REDNESS
- ☐ HOARSENESS
- ☐ NOSE BLEEDS
- ☐ ORAL ULCERS
- ☐ SORE THROAT

IMMUNOLOGY:
- ☐ SWOLLEN GLANDS
- ☐ TONSILLITIS

BREAST:
- ☐ BREAST MASS
- ☐ BREAST PAIN
- ☐ NIPPLE DISCHARGE
- ☐ SKIN CHANGES

RESPIRATORY:
- ☐ ALLERGIES/ SINUS PROBLEMS
- ☐ ASTHMA
- ☐ CHRONIC COUGH
- ☐ COUGHING UP BLOOD
- ☐ DIFFICULTY BREATHING
- ☐ EMPHYSEMA
- ☐ EXERCISE INTOLERANCE
- ☐ SPUTUM PRODUCTION
- ☐ WHEEZING

CARDIOVASCULAR:
- ☐ AORTIC ANEURYSM
- ☐ CHEST PAIN / ANGINA
- ☐ HEART PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ LEG PAINS WITH WALKING
- ☐ LEG SWELLING
- ☐ NIGHT AWAKING (BREATHING)
- ☐ PALPITATIONS
- ☐ SHORTNESS OF BREATH

HEPATOLOGY:
- ☐ HEPATITIS (A)
- ☐ HEPATITIS (B)
- ☐ HEPATITIS (C)
- ☐ OTHER LIVER CONDITIONS

NEPHROLOGY:
- ☐ DIALYSIS
- ☐ KIDNEY CONDITIONS
- ☐ KIDNEY STONES

GASTROINTESTINAL:
- ☐ ABDOMINAL PAIN
- ☐ ACID REFLUX
- ☐ CHANGE IN BOWEL HABITS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ IRRITABLE BOWEL
- ☐ NAUSEA
- ☐ RECTAL BLEEDING
- ☐ TROUBLE SWALLOWING
- ☐ ULCER(S)
- ☐ VOMITING

GENITOURINARY:
- ☐ BLOOD IN URINE
- ☐ DIFFICULT STRT/STP URINE
- ☐ IMPOTENCE
- ☐ INCREASED FREQUENCY
- ☐ LOSS OF BLADDER CONTROL
- ☐ MENSTRUAL IRREGULARITIES
- ☐ NIGHTTIME URINATION
- ☐ PAINFUL URINATION
- ☐ PENILE LESIONS
- ☐ TESTICULAR MASS
- ☐ TESTICULAR PAIN
- ☐ URETHRAL DISCHARGE
- ☐ URINARY RETENTION
- ☐ URINARY STREAM CHANGE
- ☐ VAGINAL DISCHARGE

MUSCULOSKELETAL:
- ☐ DECREASED RANGE OF MOTION
- ☐ JOINT ACHES / PAINS
- ☐ JOINT REDNESS
- ☐ JOINT STIFFNESS
- ☐ JOINT SWELLING
- ☐ MUSCLE ACHES / PAINS
- ☐ MUSCLE WASTING
- ☐ MUSCLE WEAKNESS
- ☐ NECK PAIN
- ☐ JAW PAIN (LEFT)
- ☐ JAW PAIN (RIGHT)
- ☐ SHOULDER PAIN (LEFT)
- ☐ SHOULDER PAIN (RIGHT)
- ☐ ARM / ELBOW PAIN (LEFT)
- ☐ ARM / ELBOW PAIN (RIGHT)
- ☐ WRIST / HAND PAIN (LEFT)
- ☐ WRIST / HAND PAIN (RIGHT)
- ☐ UPPER BACK PAIN
- ☐ MIDDLE BACK PAIN
- ☐ LOWER BACK PAIN
- ☐ SACROILIAC / COCCYX PAIN
- ☐ HIP PAIN (LEFT)
- ☐ HIP PAIN (RIGHT)
- ☐ LEG PAIN (LEFT)
- ☐ LEG PAIN (RIGHT)
- ☐ KNEE PAIN (LEFT)
- ☐ KNEE PAIN (RIGHT)
- ☐ ANKLE PAIN (LEFT)
- ☐ ANKLE PAIN (RIGHT)
- ☐ FOOT PAIN (LEFT)
- ☐ FOOT PAIN (RIGHT)

NEUROLOGICAL:
- ☐ DIZZINESS / VERTIGO
- ☐ HEADACHES
- ☐ LOSS OF BOWEL CONTROL
- ☐ MIGRAINES
- ☐ NUMBNESS / TINGLING
- ☐ PASSING OUT
- ☐ SEIZURES / EPILEPSY
- ☐ TREMORS

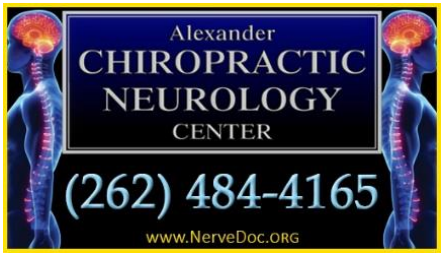
PSYCHIATRIC:
- ☐ ANXIETY
- ☐ CHANGE IN SLEEP PATTERN/PROB.
- ☐ DEPRESSION
- ☐ HALLUCINATIONS
- ☐ NERVOUSNESS
- ☐ SUICIDAL THOUGHTS

ENDOCRINE:
- ☐ APPETITE CHANGES
- ☐ COLD INTOLERANCE
- ☐ DIABETES
- ☐ HAIR CHANGES
- ☐ INCREASED THIRST
- ☐ INCREASED URINATION
- ☐ SEXUAL DYSFUNCTION

HEMATOLOGY:
- ☐ EASY BRUISING
- ☐ ENLARGED LYMPH NODES
- ☐ PROLONGED BLEEDING

PATIENT / PARENT OR GUARDIAN'S SIGNATURE: _____ **DATE:** ____ / ____ / ____

IF PARENT OR GUARDIAN'S SIGNATURE PLEASE PROVIDE (TITLE). MONTH DAY YEAR



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HEALTH QUESTIONNAIRE

HAVE YOU EVER HAD? (IF YES, CHECK APPROPRIATE BOXES)

- ☐ CANCER TYPE: _____
- ☐ HEART ATTACK/CORONARY
- ☐ ARTERY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ HEART FAILURE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ STROKE
- ☐ DIABETES
- ☐ GALLSTONES
- ☐ LIVER DISEASE
- ☐ HEPATITIS / JAUNDICE
- ☐ ULCER DISEASE
- ☐ HEARTBURN / REFLUX
- ☐ ASTHMA
- ☐ SEIZURES
- ☐ EMPHYSEMA
- ☐ PNEUMONIA
- ☐ TUBERCULOSIS
- ☐ POSITIVE TB SKIN TEST
- ☐ OSTEOPOROSIS
- ☐ ARTHRITIS
- ☐ GOUT
- ☐ FREQUENT BLADDER INFECTION
- ☐ KIDNEY STONES
- ☐ KIDNEY DISEASE
- ☐ POLIO
- ☐ CHICKEN POX
- ☐ INFECTIOUS MONO
- ☐ ANEMIA
- ☐ FREQUENT SINUS INFECTIONS
- ☐ GLAUCOMA
- ☐ THYROID TROUBLE
- ☐ HIVES
- ☐ DEPRESSION
- ☐ HEAD INJURY
- ☐ BROKEN BONES
- ☐ BLOOD TRANSFUSIONS

STD (SEXUALLY TRANSMITTED DISEASES)

- ☐ HERPES
- ☐ HIV
- ☐ GONORRHEA
- ☐ CHLAMYDIA
- ☐ SYPHILIS
- ☐ INTRAVENOUS DRUG ABUSE
- ☐ NEEDLE INJURY
- ☐ MUMPS
- ☐ MIGRAINES
- ☐ PROSTATE ENLARGEMENT
- ☐ CYSTIC FIBROSIS
- ☐ MALARIA
- ☐ OTHER:

IMMUNIZATIONS:

- ☐ MEASLES, MUMPS & RUBELLA
- ☐ CHICKEN POX VACCINE
- ☐ HEPATITIS B VACCINE
- ☐ INFLUENZA VACCINE
- ☐ PNEUMOCOCCAL VACCINE
- ☐ TETANUS BOOSTER

PAST SURGICAL HISTORY? (IF YES, CHECK APPROPRIATE BOXE/S AND ENTER THE YEAR)

- ☐ EYES (LASER OR VISION CORRECTION) YEAR- _____
- ☐ EYES (CATARACT / GLAUCOMA) YEAR- _____
- ☐ EARS YEAR- _____
- ☐ SINUS / NASAL SEPTUM YEAR- _____
- ☐ TONSILS / ADENOID YEAR- _____
- ☐ THYROID YEAR- _____
- ☐ HEART YEAR- _____
- ☐ STOMACH YEAR- _____
- ☐ VARICOSE VEINS YEAR- _____
- ☐ GALL BLADDER YEAR- _____
- ☐ APPENDIX YEAR- _____
- ☐ INTESTINE / COLON YEAR- _____
- ☐ HEMORRHOIDS YEAR- _____
- ☐ HERNIA YEAR- _____
- ☐ BREAST YEAR- _____
- ☐ UTERUS / HYSTERECTOMY YEAR- _____
- ☐ OVARIES YEAR- _____
- ☐ C-SECTION YEAR- _____
- ☐ TUBAL LIGATION YEAR- _____
- ☐ SPINAL SURGERY (NECK) YEAR- _____
- ☐ SPINAL SURGERY (BACK) YEAR- _____
- ☐ PROSTATE YEAR- _____
- ☐ VASECTOMY YEAR- _____

ORTHOPEDIC:

- ☐ HIPS YEAR- _____
- ☐ KNEES YEAR- _____
- ☐ SHOULDER / FEET / HANDS YEAR- _____

GYNECOLOGICAL / OBSTETRICAL HISTORY

NAME OF OB-GYN: _____ AGE AT MENOPAUSE- _____

AGE WHEN YOU STARTED MENSTRUATING? _____ MENSTRUAL CYCLES? REGULAR- ☐ IRREGULAR- ☐ PAIN W/PERIODS YES- ☐ NO- ☐

DATE OF LAST PAP? _____ HISTORY OF ABNORMAL PAP'S NO- ☐ YES- ☐ _____

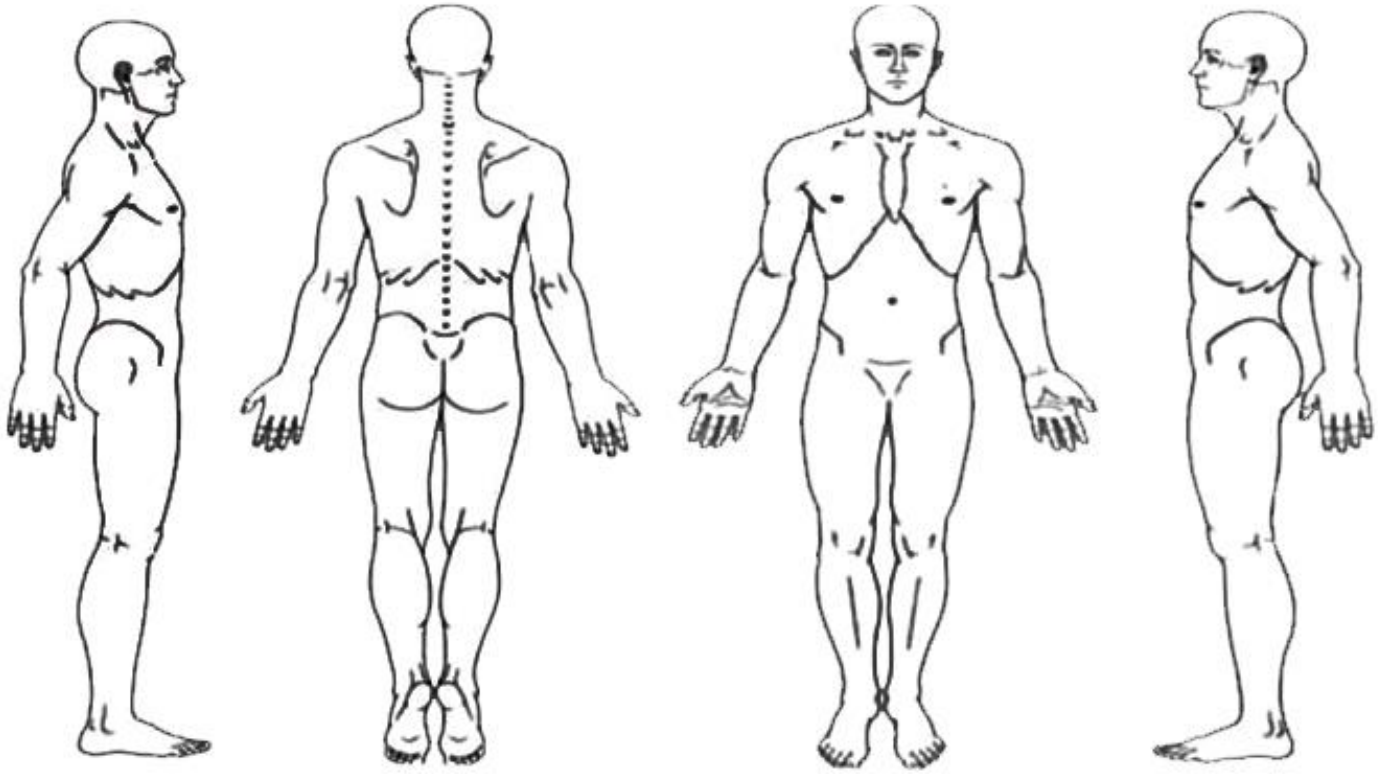
DATE OF LAST MAMMOGRAM? _____ HISTORY OF ABNORMAL MAMMOGRAMS NO- ☐ YES- ☐ _____

NUMBER OF PREGNANCIES? _____ NUMBER OF BIRTHS? _____ # OF VAGINAL- _____ #OF C-SECTION- _____

METHOD OF CONTRACEPTION- _____

SYMPTOM GEOGRAPHY? (PLEASE MARK ON THE BODIES)

NOTE: INDICATE THE AREA ON EACH BODY WHERE YOU ARE EXPERIENCING ANY DYSFUNCTION, DISCOMFORT OR PAIN; WITH THE CORRESPONDING SYMPTOM AND DEGREE RATING



RIGHT SIDE **BACK** **FRONT** **LEFT SIDE**

SYMPTOM KEY:

PAIN=	XXX	1-10	BURNING=	BBB	1-10	ACHE=	AAA	1-10	SHOOTING=	SHSHSH	1-10
NUMBNESS=	OOO	1-10	TINGLING=	TTT	1-10	SHARP=	SPSPSP	1-10			

PAST FAMILY HISTORY? (IF YES, CHECK APPROPRIATE BOXE/S AND LIST RELATIONSHIP)

☐	CANCER	WHO-	☐	DIALYSIS	WHO-	☐	CROHN'S / COLITIS	WHO-
☐	DIABETES	WHO-	☐	CHRONIC LUNG DISEASE	WHO-	☐	ALZHEIMER'S	WHO-
☐	CARDIAC DYSRHYTHMIA	WHO-	☐	TUBERCULOSIS	WHO-	☐	ALCOHOLISM	WHO-
☐	CONGESTIVE HEART FAILURE	WHO-	☐	RHEUMATOID ARTHRITIS	WHO-	☐	BLEEDING TENDENCY	WHO-
☐	CORONARY ARTERY DISEASE	WHO-	☐	THYROID TROUBLE	WHO-	☐	ANEMIA	WHO-
☐	VALVULAR HEART DISEASE	WHO-	☐	OSTEOPOROSIS	WHO-	☐	GOUT	
☐	HIGH BLOOD PRESSURE	WHO-	☐	CYSTIC FIBROSIS	WHO-	☐	DEPRESSION	WHO-
☐	HIGH CHOLESTEROL	WHO-	☐	ASTHMA	WHO-	☐	MENTAL ILLNESS	WHO-
☐	STROKE	WHO-	☐	PEPTIC ULCER	WHO-	☐	SEIZURES	WHO-
☐	KIDNEY STONES	WHO-	☐	GALLSTONES	WHO-	☐	MIGRAINE HEADACHES	WHO-
☐	KIDNEY DISEASE	WHO-						

☐ OTHER: _____

PATIENT / PARENT OR GUARDIAN'S SIGNATURE: _____ **DATE:** ____ / ____ / ____

IF PARENT OR GUARDIAN'S SIGNATURE PLEASE PROVIDE (TITLE). MONTH DAY YEAR