

PERSONAL HISTORY

Date _____

Dear Patient:

Please complete this questionnaire. Your answers will assist us in determining if Chiropractic can help you. Please answer ALL questions. Even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name _____ Preferred Name _____

Mailing Address _____ City _____

Postal Code _____ Email Address _____

Phone: Home _____ Work _____ Cell _____

Health Care No. _____ Age _____ Weight _____ Height _____

Birth date - Day _____ Month _____ Year _____ Birthplace _____

Gender (M / F) Marital Status (S / M / W / D / CL) Spouse's Name _____ # of Children _____

Occupation _____ Employer _____

Referred to this office by _____ Family M.D. _____

Who is responsible for your bill? Self Spouse Parent or Guardian Other _____

CURRENT HEALTH CONDITION

Present complaint _____

Have you had any previous treatment for this condition? _____

When did this condition begin? _____ Is this a WCB case? _____

What do you believe caused this condition? _____

Are there others in your family with this same condition? _____

Have you had any time loss from work for this condition? (If recent list dates) _____

Are you presently taking medication? (please list) _____

PAST HEALTH HISTORY

Major surgery/operations: Appendix Tonsils Gall Bladder Hernia
 Heart Back Neck Leg
 Other _____

Major accidents or falls _____

Previous Chiropractic Care _____

Previous Massage Therapy _____

Have you been treated for any health condition in the last year? Yes No

If yes, please explain _____

Check any conditions which are presently causing you a problem. Please underline which were a problem in the past.

GENERAL

- Headache
- Numbness or tingling in arms or legs
- Dizziness
- Ringing in ears
- Whiplash
- Fainting
- Earache
- Sore throat
- Nose bleeds
- Sinus problems
- Asthma
- Enlarged glands
- Loss of weight
- Hypoglycemia
- Nervousness
- Depression/confusion
- Vision problems
- Dental problems
- Hearing problems
- Sleep problems

ORGANS

- Frequent urination
- Painful urination
- Blood in urine
- Bladder trouble
- Kidney stones
- Bed wetting
- Prostate problems
- Sexual dysfunction
- Anemia
- Thyroid
- Excessive appetite
- Gas/bloating
- Nausea or vomiting
- Constipation/diarrhea
- Colitis
- Black/bloody stool
- Hemorrhoids
- Liver trouble
- Gallbladder trouble

MUSCLE & JOINT

- Sore joints
- Sore muscles
- Low back problems
- Neck problems
- Painful tailbone
- Pain between shoulders
- Spinal curvature
- Arthritis
- Walking problems
- Broken bones
- Jaw problems (TMJ)
- Ankle swelling
- Limb pain

SKIN

- Eczema
- Skin eruptions
- Varicose veins

FEMALES ONLY

- Painful periods
- Irregular cycle
- Cramps, backache
- Vaginal discharge/infection
- Lumps/pain in breast
- Previous miscarriage
- Unable to get pregnant
- Hot flashes

RESPIRATORY & HEART

- Lung problems
- Chronic cough
- Spitting up blood
- Frequent colds/flu
- Shortness of breath
- Difficulty breathing
- Heart problems

Are you pregnant?

- Yes
- No
- Not sure

When was your last period? _____

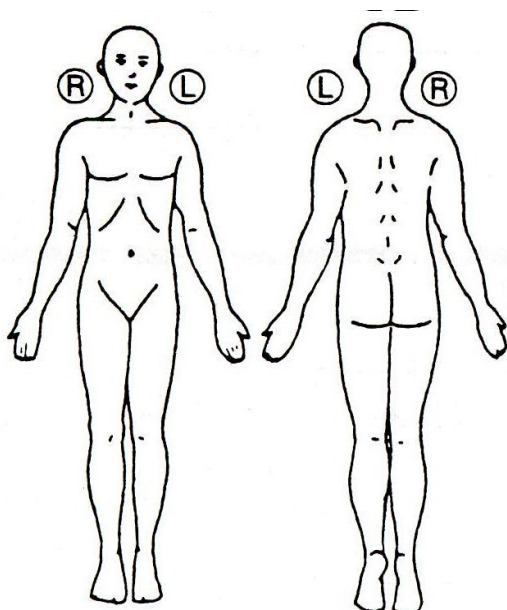
Check any of the following diseases you have had:

- Alcoholism
- Tuberculosis
- Venereal infection
- Rheumatic fever
- Epilepsy
- Diabetes
- Stroke
- Cancer
- Arthritis
- Allergies
- Hypoglycemia
- Heart disease

Has anyone in your family had any of the following diseases?

- Heart disease
- High blood pressure
- Cancer
- Stroke
- Arthritis

Please indicate any areas of discomfort



Lifestyle

	none	light	moderate	heavy
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>