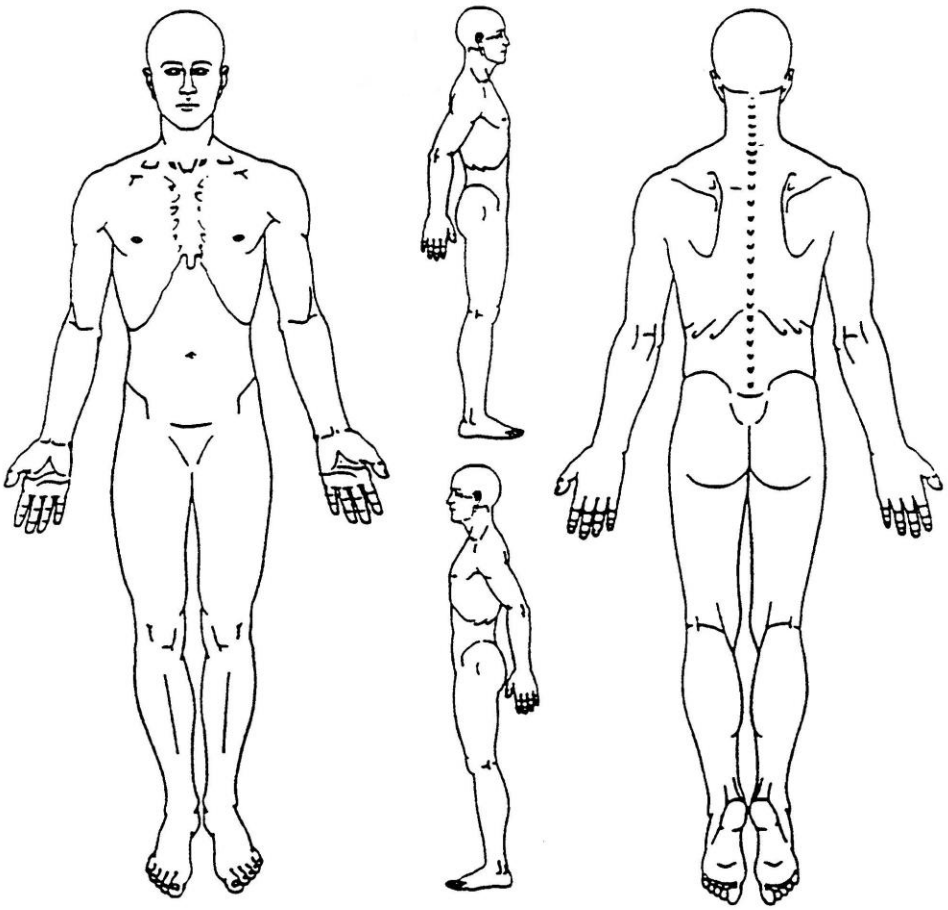
Patient Name: _____ **Date** __ /___ /___

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?

GENERAL:
☐ **Normal**
☐Fatigue
☐ Weakness
☐ Fever
☐ Chills
☐ Gain weight or loss
☐ Night sweats
☐ Other: _____

SKIN:
☐ **Normal**
☐ Rash
☐ Itching
☐ Eczema
☐ Hair changes
☐ Nail changes
☐ Other: _____

EYES:

☐ **Normal**	**R**	**L**
Vision Trouble	☐	☐
Pain	☐	☐
Discharge	☐	☐

☐ Other: _____

EARS:

☐ **Normal**	**R**	**L**
☐Hearing Trouble	☐	☐
☐Ringing	☐	☐
☐Pain	☐	☐

☐ Other_____

NOSE:
☐ **Normal**
☐ Pain
☐ Bleeding
☐ Absence of smell
☐ Other_____

MOUTH/THROAT:
☐ **Normal**
☐ Sores
☐ Dryness
☐ Other_____

NEUROLOGIC:
☐ **Normal**
☐ Headache
☐ Dizziness
☐ Convulsions
☐ Other_____

GLANDULAR
☐ **Normal**
☐ Hot/Cold Intolerance
☐ Sugar in urine
☐ Goiter
☐Tremor
☐ Other_____

MENTAL:
☐ **Normal**
☐ Anxiety
☐ Depression
☐ Memory loss or impairment
☐ Phobias
☐ Mood Swings
☐ Other_____

HEART:
☐ **Normal**
☐ Murmur
☐ Chest Pain
☐ Palpitations
☐ Swollen Extremities
☐ Other_____

LUNGS:
☐ **Normal**
☐ Cough
☐ Wheezing
☐ Difficulty Breathing
☐ Blue Extremities
☐ Other_____

BREASTS:
☐ **Normal**
☐ Lumps in breast(s)
☐ Redness/Itching
☐ Pain
☐ Dimpling
☐ Discharge
☐ Other_____

STOMACH/INTESTINES:
☐ **Normal**
☐Decreased Appetite
☐ Increased Appetite
☐ Abdominal
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Other_____

REPRODUCTIVE/URINATION:
☐ **Normal**
☐ Inability to hold urine
☐ Painful Urination
☐ Frequent Urination
☐ Irregular Menstruation
☐ Painful Menstruation
☐ Abnormal Vaginal Bleeding
☐ Impotence
☐ Sterility
☐ Other_____

2. What Are Your Habits? (Please circle)

Smoking: Never a smoker Former smoker Packs per day : <1 1-2 2-3 3-4 5+

Alcohol: Abstains Former alcoholic Glasses per day: <1 1-2 2-3 3-4 5+

Drug/Substance Use: Never Occasionally Moderately Excessive

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
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

_____

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) _____		☐ Other _____	

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

Patient's Signature: _____ Date: _____