# CHIROPRRACTIC HEALTH QUESTIONAIRE

Date _____

Patient Name _____ Birth date _____

Reason for visit _____

Have you been treated before for this problem? ☐ No ☐Yes

If yes, by ☐Physician ☐Chiropractor ☐ Physical Therapist ☐Osteopath ☐Other _____

What did they do and/or recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Is it constant or does it come and go? _____ Does it interfere with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down

☐ Other _____

Your Occupation _____

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes ☐ When? _____

Do you take ☐Muscle relaxers ☐Pain killers ☐ Insulin ☐ Birth Control pills ☐ Over-the-counter meds

☐Other prescription drugs _____ Please list all medication in the space at the bottom of the page.

Date of last: Physical exam _____ Spinal x-ray _____ Blood test _____

Spinal exam _____ Chest x-ray _____ Urine test _____

Dental x-ray _____ MRI, CT-scan, bone scan _____

Sleep _____hrs/night Do you sleep on your ☐Back ☐ Side ☐ Stomach Non-job exercise _____hrs/wk

Age of mattress _____ or waterbed _____ Is your bed comfortable? ☐ No ☐Yes

What kind of pillow do you use? ☐Thick ☐ Medium ☐ Thin ☐ None ☐ Support

Do you wear ☐ Heel lifts ☐ Shoe lifts ☐Arch supports ☐ Orthotics, describe _____

**CONDITIONS** Check (✓) conditions you have or have had in the past.

| | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Diabetes | ☐ Liver Disease | ☐ Rheumatic fever |
| ☐ Alcoholism | ☐ Emphysema | ☐ Measles | ☐ Scarlet fever |
| ☐ Anemia | ☐ Epilepsy | ☐ Migraine headaches | ☐ Stroke |
| ☐ Anorexia | ☐ Fractures | ☐ Miscarriage | ☐ Suicide attempt |
| ☐ Appendicitis | ☐ Glaucoma | ☐ Mononucleosis | ☐ Thyroid problems |
| ☐ Arthritis | ☐ Goiter | ☐ Multiple sclerosis | ☐ Tonsillitis |
| ☐ Asthma | ☐ Gonorrhea | ☐ Mumps | ☐ Tuberculosis |
| ☐ Bleeding disorders | ☐ Gout | ☐ Osteoporosis | ☐ Tumors, growths |
| ☐ Breast lump | ☐ Heart Disease | ☐ Pacemaker | ☐ Typhoid fever |
| ☐ Bronchitis | ☐ Hepatitis | ☐ Pneumonia | ☐ Ulcers |
| ☐ Bulimia | ☐ Hernia | ☐ Polio | ☐ Vaginal infections |
| ☐ Cancer | ☐ Herpes | ☐ Prostate problem | ☐ Venereal disease |
| ☐ Cataracts | ☐ High Cholesterol | ☐ Prosthesis | ☐ Whooping cough |
| ☐ Chemical dependency | ☐ HIV positive | ☐ Psychiatric care | ☐ Other _____ |
| ☐ Chicken pox | ☐ Kidney disease | ☐ Rheumatoid arthritis | _____ |

**MEDICATIONS** List medications you are currently taking

_____

_____

_____

_____

Allergies_____

Pharmacy Name_____ Phone_____

**VITAMINS/HERBS/MINERALS**

_____

_____

_____

_____