Name_____

Today's Date_____

Health Questionnaire

CURRENT CONDITION

What is your main health complaint or symptom? (Why are you here today?): _____

_____

When Did This Condition BEGIN?: _____

At the Onset of This Condition were the symptoms: ❑ Gradual ❑ Sudden

Is This Condition:

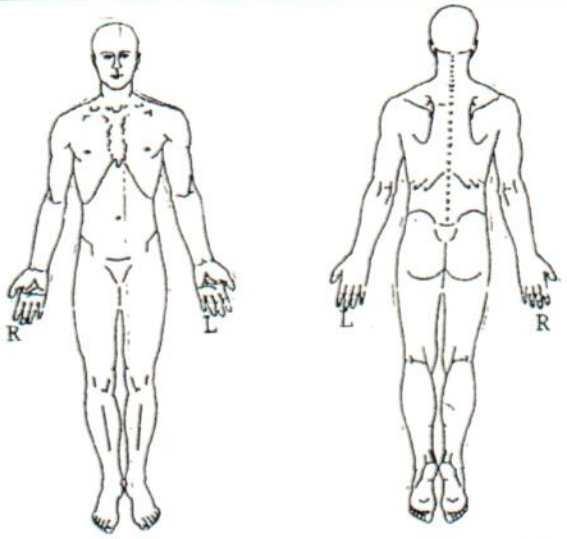
❑ Auto Related ❑ Job Related ❑ Home Injury ❑ Slip & Fall ❑ Lifting

❑ Slept Wrong ❑ Unknown ❑ Other_____

Has It Ever Occurred Before?: ❑ No ❑ Yes If Yes, When?: _____

Please CHECK All that Apply, Then Use the Letters Below to Indicate the TYPE and LOCATION of Your Symptoms

❑Dizziness
❑Memory loss
❑Headaches
❑Blurred vision
❑Buzzing/Ringing in ear
❑Difficulty Sleeping
❑Tension
❑Neck Pain
❑Neck Stiffness/Tightness
❑Shoulder/Arm Pain
❑Numb Hand/Fingers
❑Shortness of Breath
❑Nausea
❑Mid Back Pain
❑Low Back Pain
❑Back Stiffness/Tightness
❑Hip Pain
❑Leg Pain



A = Aching B = Burning N = Numbness H = Sharp
P = Pins & Needles S = Stabbing T = Throbbing D = Dull
G = Tightness (S)= Shooting (T)= Tingling (D) = Deep

TIMING of CURRENT CONDITION

Are These Symptoms: ❑Constant ❑Frequent ❑Occasional ❑Random ❑Mild ❑Moderate ❑Severe

Worse In: ❑Morning ❑Afternoon ❑ Night ❑Just Before Bed ❑Other_____

Level of Discomfort Right Now Due to Symptoms:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Frequency of Discomfort Right Now Due to Symptoms:

None 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Constant

How Bad is your Discomfort at it's Worst?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

How Bad is your Discomfort at it's Best?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please Continue on Back

PREVIOUS CARE

Family Doctor: _____

Have you seen any other doctors for THIS CONDITION? ❑ No ❑ Yes If yes, Name of Doctor / Hospital

_____

Type of Treatment: _____

_____

Was the treatment beneficial in resolving condition? ❑Yes ❑No Explain: _____

What activity does this problem prevent you from doing, either partially or totally, that you would really like to be doing again? _____

CURRENT MEDICATION

Medication	Dosage	For What Condition?	How Long

SURGERY / ILLNESS HISTORY

Please (CIRCLE) All That Apply:

ADD/ADDH	Allergies	Alzheimer's	Anemia
Anxiety	Asthma	Birth Defects	Breathing Problems
Chest Pain	Convulsions	Depression	Diabetes
Dizziness	Double Vision	Electronic Implant	Fatigue
Fainting	Fibromyalgia	Fractured Bones	Head Injury
Hearing Problems	Heart Disease	High Blood Pressure	History of Blood Clots
HIV	Imbalance	Irregular Heart Beat	Joint Dislocation
Joint Replacement	Leg Cramps	Lightheadedness	Liver Problems
Loss of Consciousness	Memory Problems	Metal Screw/Implants	Migraine Headaches
Muscle Weakness	Nervousness	Osteoporosis	Poor Coordination
Ringing in the Ears	Scoliosis	Seizures	Shortness of Breath
Herniated Disc	Spinal Fusion	Spinal Injections	Spinal Surgery
Stroke	Thyroid Problems	Tremors	Tumor
Vertigo	Vision Problems	Other: _____	

_____

_____

_____