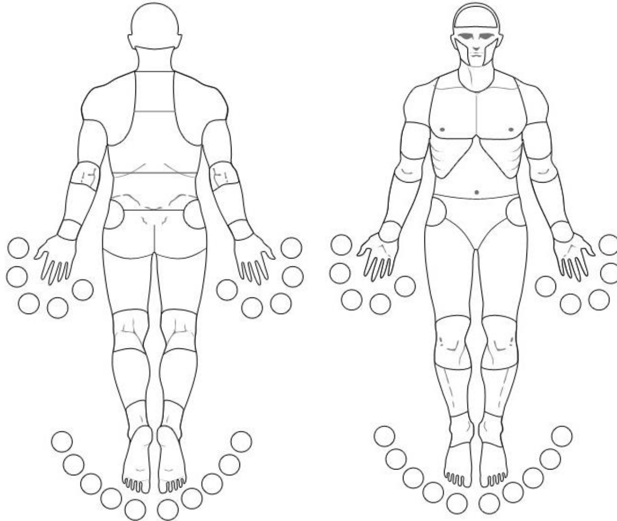
Initial Health Questionnaire

Name: ______________________ Date __________ Patient Number: ____________

I. Patient Complaints:



1. Please shade in the areas on the diagram where you are having pain or other symptoms

2. Please rate your pain today: (circle one)
0 1 2 3 4 5 6 7 8 9 10

3. Description of pain:
Please choose the description(s) that apply to your complaint.
☐ Numbness ☐ Tingling ☐ Stiffness
☐Tightness ☐ Swelling ☐ Weakness

☐Sharp pain ☐ Dull pain ☐ Shooting
☐ Aching ☐ Throbbing

4. Frequency of complaint:
Please choose the frequency of your complaint(s) and indicate the area(s) on the body that correspond.
☐ Constant (76%-100%) ______________________________
☐ Frequent (51%-75%) ______________________________
☐ Occasional (26%-50%) ______________________________
☐ Intermittent (25% or less) ______________________________

5. How/When did your complaints begin:
☐ Unknown ☐ Suddenly ☐ Gradually Date: ____________
Comments: ______________________________

6. When are your symptoms worse?
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All day

7. What makes your symptoms worse?
☐ Nothing ☐ Sneezing ☐ Bending ☐ Reaching ☐ Standing
☐ Turning ☐ Coughing ☐ Lifting ☐ Walking ☐ Sitting
☐ Straining at stool ☐ Other ______________________________

8. What makes your condition better?
☐ Nothing ☐ Heat ☐ Massage ☐ Stretching ☐ Medications
☐ Rest ☐ Ice ☐ Standing/Standing ☐ Exercise ☐ Other: ______

Patient Name: ____________________________

9. Have any of your complaints existed in the past?

☐ Neck ☐ Upper back ☐ Mid back ☐ Low Back ☐ Ribs ☐ Hands/Fingers
☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Buttock
☐ Hip ☐ Thigh ☐ Knee ☐ Leg/Calf ☐ Ankle ☐ Foot

10. Have you had any treatment of your conditions OUTSIDE this office?

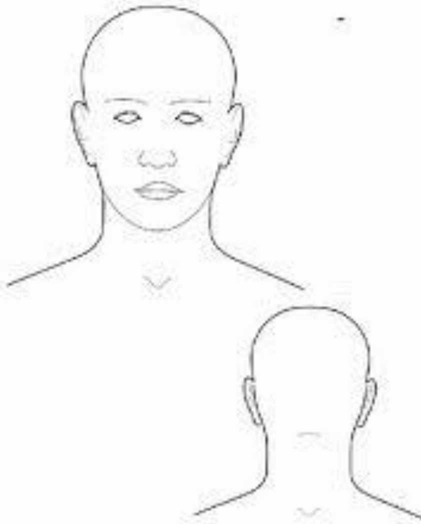
☐ YES ☐ NO If Yes list Dates, Treatments, and Doctors.

____

____

II. Headaches:

If you are experiencing headaches, Please fill out this section, otherwise skip to Section 3.



1. Please shade in the areas that are associated with your headache pain.

2. On what date did your headaches begin?
Date: ______________ ☐ Same date as other symptoms

3. How does the intensity of your headaches rate? (circle one)
0 1 2 3 4 5 6 7 8 9 10

4. Description of Pain:
☐ Dull ☐ Deep ☐ Aching
☐ Sharp ☐ Vice-like ☐ Burning
☐ Stabbing ☐ Throbbing/Pulsating
☐ Other ______________________________________

5. When do your headaches usually start?
☐ Constant/Anytime awake ☐ Wake up with in the morning
☐ At midday ☐ During the evening

6. What seems to bring on your headaches?
☐ Physical activity ☐ Caffeine ☐ Certain foods ☐ Menstrual Period
☐ Excessive Stress ☐ Alcohol ☐ Other: ______________________________________

7. How often do they occur:
☐ _____ times per week ☐ _____ times per month ☐ Other:____________________

8. How long do your headaches last?
☐ Less than 1 hour ☐ From 1-3 hours ☐ Longer than 3 hours ☐ Several hours to days
☐ Other: ______________________________

9. Do any of the following occur with your headaches?
☐ Nausea/Vomiting ☐ Weakness ☐ Tremor ☐ Vision problems ☐ Dizziness
☐ Light/Sound sensitivity ☐ Other: ____________________________________

Patient Name: ____________________________

10. What makes your headaches better?

☐ Nothing ☐ Rest ☐ Lying down ☐ Ice/Cold packs ☐ Massage ☐ Standing
☐ NSAIDS (Aspirin, Tylenol, etc.) ☐ Other: ____

III. Other Complaints:

Do you have any other complaints not covered on this form? ☐ YES ☐ NO

If Yes, Describe other complaints in detail here.

____

____

IV. Current Symptoms:

1. Are you currently suffering from any of the symptoms below?

☐ None of the symptoms listed below

☐ General Fatigue/Weakness	☐ Hay Fever	☐ Asthma
☐ Nose/sinus pain	☐ Weight change (unplanned)	☐ Night sweats
☐ Pacemaker	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Anemia	☐ Bruise Easily	☐ Diabetes
☐ Dizziness/Fainting	☐ Thyroid Trouble	☐ Ulcer
☐ Convulsions	☐ Epilepsy	☐ Anxiety
☐ Depression	☐ Nervousness	☐ Prostrate Trouble
☐ Arthritis	☐ Scoliosis	☐ Excessive drainage
☐ Nose bleeds (chronic)	☐ Sinus Trouble (chronic)	☐ Eczema (red, inflamed skin
☐ Cough (chronic)	☐ Wheezing (chronic)	☐ Cardiovascular Disease
☐ Difficulty breathing	☐ Swollen extremities	☐ Varicosities (visible veins)
☐ Rapid heartbeat	☐ Chest pain	☐ Heart palpitations
☐ Heart murmur	☐ Abdominal pain	☐ Diverticulitis
☐ Change in bowel or bladder	☐ Tuberculosis	☐ Bone Fractures:__________
☐ Cancer:______________	☐ Spinal Disc Disease	☐ Kidney Trouble:_________
☐ Multiple Sclerosis		

	Left	Right
Hearing Trouble	☐	☐
Ringing in ears	☐	☐
Pain in ears	☐	☐
Ear discharge	☐	☐
Vision Trouble	☐	☐
Pain in eyes	☐	☐
Eye discharge	☐	☐

☐ Other symptoms not listed (please describe):

____

____

____

____

____

____

Patient Name: ______________________________

V. Habits/Activities:

Smoking (Packs per day)................................ ☐ Never ☐<1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+
Caffeinated drinks (glasses per day)......... ☐ Never ☐<1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+
Alcohol (glasses per day)................................ ☐ Never ☐<1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+
Drug/Substance Abuse........................ ☐ NO ☐ YES (if Yes, discuss with doctor)

Exercise.. Days per week= ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
Kinds of Exercise You Do:
☐ Walking ☐ Jogging ☐ Cycling ☐ Swimming ☐ Tennis ☐ Strength training
☐ Golf ☐ Other: ______________________________

VII. Medical History:

1. Health Care:

a. Have you ever been to a Chiropractor? ☐ YES ☐ NO
b. Do you have a Family Physician? ☐ YES ☐ NO
Date of last physical exam: ______________________________
Physician's Name: ______________________________
Address: ______________________________
c. Have you been hospitalized in the past? ☐ YES ☐ NO
Date & Reason for hospitalization: ______________________________
____
d. Have you had surgery in the past? ☐ YES ☐ NO
Date, Reason, & Results of surgery: ______________________________
____
____
e. Have you ever had a serious accident or injury? ☐ YES ☐ NO
List Date & Describe Injury:
☐ Auto: ______________________________
☐ Work-Related: ______________________________
☐ Personal: ______________________________
☐ Sports Injury: ______________________________
☐ Other: ______________________________
f. Are you currently taking any vitamins, minerals, or herbs? ☐ YES ☐ NO
List supplements: ______________________________
____
g. Are you currently taking any medications? ☐ YES ☐ NO
For what conditions are you taking medication?
☐ Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.) ______________________________
☐ Pain/Analgesics: ______________________________
☐ Anti-Depressents: ______________________________
☐ Muscle Relaxants: ______________________________
☐ Antibiotics: ______________________________
☐ Birth Control Pills: ______________________________

Patient Name: ___________________________

☐ Corticosteroid:____

☐ Other:____

In the past have you used any of the following?

☐ Birth Control Pills ☐ Corticosteroid

h. Are you allergic to any Medications? ☐ YES ☐ NO

List Medications: ____

i. WOMEN ONLY:

To your knowledge are you pregnant? ☐ YES ☐ NO

If pregnant in past, were pregnancies normal? ☐ YES ☐ NO

Number of births? (circle one) 1 2 3 4 5 Other: __________

Are you seeing an OB-GYN regularly? ☐ YES ☐ NO

Date of Last Exam:____

Physician's Name:____

Address:____

VIII. Family History:

Please indicate if any of your immediate family has had the following conditions:

☐ Cancer	☐ Diabetes	☐ Heart Trouble	☐ High Blood Press.
☐ Stroke	☐ Kidney Disease	☐ Anemia	☐ Mental Illness
☐ Headaches	☐ Osteoporosis	☐ Arthritis	☐ Joint Problems
☐Scoliosis	☐ Back Problems	☐ Disc Problems	☐ Congenital Disease
☐ Genetic Disease	☐ Other:________________________________		

VIIII. Occupational Information/ Activities of Daily Living:

1. Are you right or left Handed ☐ Right ☐ Left

2. Job Type: ☐ Retired ☐ Unemployed ☐ Full-Time Student

If any of the above are chosen, skip the rest of this form.

☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Self-Employed

☐ Stay At Home Parent ☐ Other: ______________________

3. Where are you currently employed? ________________________

4. What is your Job Title?_________________________________

5. During your work week, you work how many:

Hours per day (circle one) 1 2 3 4 5 6 7 8 9 10 11 12

Days per week (circle one) 1 2 3 4 5 6 7

Other: ____

6. How long have you been with your present employer? ______________________________

Patient Name: ______________________________

7. Do your present complaints affect the number of hours you work per day? ☐ YES ☐ NO

8. What is your primary work position and location?
a. Work position: ☐ Seated ☐ Standing ☐ Other _________________
b. Work location: ☐ Desk ☐ Counter ☐ Workbench ☐ Other _________________

9. What movements Does your job require?
☐ Bending ☐ Twisting ☐ Carrying ☐ Turning ☐ Walking ☐ Stooping
☐ Repetitive hand use ☐ Other ____________________

10. Does you job involve lifting?
☐ Never ☐ Occasionally ☐ Intermittently ☐ Frequently ☐ Constantly
How many pounds (circle one) 10 20 30 40 50+

11. What best describes your stress level at work?
☐ None ☐ Minimal ☐ Minimal to Moderate ☐ Moderate ☐ Moderate to Extreme ☐ Extreme

12. Do work activities aggravate your present complaints? ☐ YES ☐ NO
If yes, Explain: ____

Patient Signature		Date	

Doctor Seen	