

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
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PERSONAL HEALTH HISTORY

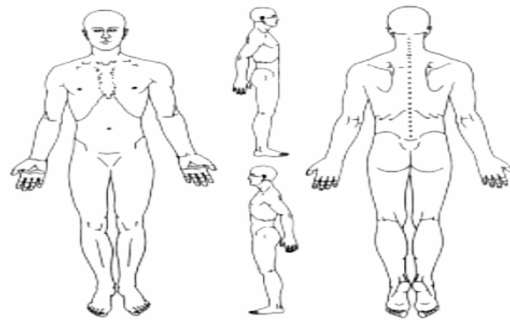
Current Complaints

Nature of Injury: Automobile Work Other

Please describe:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- | | |
|------------------|------------|
| A=Ache | B=Burning |
| P=Pins & Needles | N=Numbness |
| S=Stabbing | O=Other |



Date of Injury: Date symptoms appeared:

Have you ever had same condition: No Yes If yes, when?

List of other practitioners seen for this injury/condition:

Have you ever been under chiropractic care? No Yes

If yes, please describe:

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?		
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea
	<input type="checkbox"/> Cola		
# of cups/cans per day?			
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How many drinks per week?		
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes - pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> Cigars - #/day		
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Maternal</i>			
<input type="checkbox"/> M		Grandmother			
<input type="checkbox"/> F		<i>Paternal</i>			
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Paternal</i>			

WOMEN ONLY

Date of last menstruation:				
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you pregnant or breastfeeding?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

MEN ONLY

Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Date of last prostate and rectal exam?				

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

SIGNATURES

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____