PATIENT HISTORY QUESTIONNAIRE

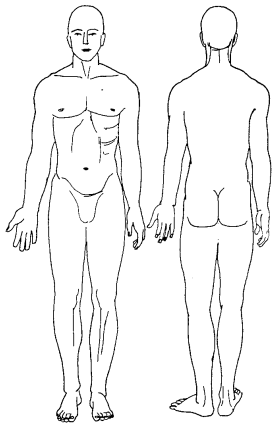
Date completed:_____

Please Print Clearly

Name: _____
Address: _____
City/State :_____
Zip Code:_____
Phone: (home) _____
(work) _____
Employer:_____
Occupation : _____
E-Mail: _____

Date of Birth: _____
Marital Status : M S D Sep W
Spouse's Name : _____
# of children : _____
# of pregnancies:_____
Who referred you to us? _____
Contact in emergency: _____
Phone #_____
Insurance Co. : _____
Policy #: _____

CURRENT PROBLEM (Please describe briefly, with date of onset, other doctors seen, diagnosis & treatment. We will discuss this fully in person. Mark areas of pain on figure.)



HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR?
FOR WHAT PROBLEM? WHEN? DID YOU GET GOOD RESULTS?

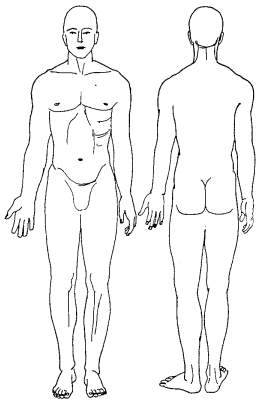
IN YOUR **WHOLE LIFE** HAVE YOU EVER HAD ANY OF THE FOLLOWING:

AUTO ACCIDENTS: (Please include date, what happened, what injuries, any X Rays taken, and treatment received.)

BAD FALLS, SPRAINS, STRAINS AND BLOWS TO THE HEAD: (describe as for accidents)

BROKEN BONES, FRACTURES: (date, what bone, any problems with healing?)
.

SURGERY:(include date, type of surgery, reason, complications, where done)
Please draw in all surgical and other scars on the figures



HOSPITALIZATIONS: (Date, what was wrong, what treatment)

SERIOUS ILLNESSES: (when? what treatment?)

Lung Disease	Autoimmune Disease
Heart Disease	Blood Disease / Anemia
Blood pressure problems	Sexually Transmitted Disease
Liver Disease	Neurological Disease / Stroke
Diabetes	Tumors
Kidney Disease	Cancer
Bone Disease	HIV / AIDS

FAMILY HISTORY: (List any close relatives who have had any of the above)

ARE YOU CURRENTLY UNDER ANY OTHER DOCTOR'S CARE (what condition? Treatment?

HEALTH EXAMINATIONS: When was your last physical exam?_____
Any problems found not previously noted?

Have you had any of the following tests? When? Where done? Results, if known?

EKG or Stress Test_____
Cholesterol/Triglycerides _____
Blood Chemistry or Screen_____
Blood sugar / HbA1C_____Urinalysis_____
Stool Analysis_____
(Women) Gynecologic Exam _____ Mammogram_____PapTest_____
(Men) Prostate Exam _____PSA_____
Dental_____Eye_____
X-RAYS: Spinal_____Chest_____Dental_____ Other_____

PLEASE EXPLAIN ANY POSITIVE FINDINGS ON LABS AND IMAGING:

VITAMINS, MINERALS, AND FOOD SUPPLEMENTS: (currently taken)

MEDICATIONS, DRUGS, OVER THE COUNTER REMEDIES TAKEN NOW: (what for? what medicine? side effects?)

PAST MEDICATIONS

(what? when?)

Hormones: __Thyroid
__Estrogen
__Progesterone
__Birth Control Pill
__Cortisone
__Testosterone
__Other_____

__Tranquilizers,
__Antidepressants
__Anti inflammatory drugs
__Long course of antibiotics
__Allergy/Asthma medicine
__Allergy shots
__Blood pressure medication
__Heart medication

__Diet pills/Amphetamines
__Pain Killers / Analgesics
__Anti convulsants
__Chemotherapy
__Other_____

ALLERGIES TO DRUGS? YES NO

DRUG FIRST TIME REACTED TYPE OF REACTION

_____
_____
_____

MAJOR DENTAL WORK / BRACES / TMJ (JAW) PROBLEMS?

ANY LEARNING DISABILITY, DYSLEXIA, INCOORDINATION, OR CONFUSION?

HAVE YOU EVER BEEN UNCONSCIOUS? (Anesthetic, knocked out, fainted?)

NUTRITION AND DAILY HABITS

ARE YOU: _____OVERWEIGHT? _____UNDERWEIGHT? _____ JUST RIGHT?
Actual current weight:_____ What weight do you consider ideal for yourself?_____

ARE YOU ON ANY SPECIAL DIET? VEGETARIAN?

ON AN AVERAGE DAY WHAT DO YOU EAT FOR:
BREAKFAST?

LUNCH?

SUPPER?

SNACKS?

SWEETS? (servings of candy, cakes, cookies, pastry, etc. per day or week?)_____

BEVERAGES: (please note amounts in average day, week, etc.)

WATER:_____ COFFEE/TEA:_____(decaf / regular?)
Water softener?_____(type)_____ MILK:_____(whole / 2% / skim?)
SODA:_____(regular / diet?) JUICE:_____
HERB TEA:_____(Type?) ALCOHOL:_____

DO YOU CRAVE ANY FOOD OR BEVERAGE?

DO YOU REACT BADLY TO ANY FOOD OR BEVERAGE? Known food allergy or intolerance?

SMOKING: Amount? Date quit?_____

ALCOHOL OR CHEMICAL DEPENDENCY:

SLEEP : How many hours do you sleep at night? _____ Any sleep difficulties?
Trouble falling asleep?____ Trouble staying asleep?____ Sleep not restful?_____

EXERCISE: Type? Frequency? Any problems?

DO YOU WEAR ANY TYPE OF ARCH SUPPORT OR ORTHOTIC? YES___ NO____

PLEASE MARK ANY CONDITIONS YOU HAVE **NOW** OR HAD IN THE **PAST**

NOW PAST

____ ____ Frequent infections
____ ____ Fever-unknown cause /long duration
____ ____ Poor wound healing
____ ____ Night sweats
____ ____ High stress level
____ ____ Insomnia
____ ____ Fatigue or Chronic Fatigue Syndrome

____ ____ Spinal curvature / Scoliosis
____ ____ Low back pain
____ ____ Pain between shoulders
____ ____ Neck pain/stiff neck
____ ____ Arm or wrist problems
____ ____ Leg problems
____ ____ Foot problems
____ ____ Swollen, painful joints,Stiff joints
____ ____ Sore muscles
____ ____ Weak muscles
____ ____ Walking difficulty
____ ____ Disc problems

____ ____ Bladder infection
____ ____ Excessive urination, night frequency
____ ____ Scanty urination
____ ____ Inability to control urine / urgency
____ ____ Bed wetting
____ ____ Kidney infection
____ ____ Kidney stones

MEN:

____ ____ Prostate problems, urine dribbling, frequency
____ ____ Breast lumps
____ ____ Testicular problems
____ ____ Hernia
____ ____ Decrease in libido

WOMEN:

____ ____ Painful menstruation
____ ____ Irregular Cycle
____ ____ Premenstrual Syndrome
____ ____ Vaginal discharge/ infection
____ ____ Vaginal dryness
____ ____ Unusual vaginal bleeding
____ ____ Vaginal pain
____ ____ Breast problems/lumps /pain
____ ____ Hot flashes/menopausal problems
____ ____ Facial hair growth
____ ____ Miscarriage
____ ____ Pregnancy

NOW PAST

____ ____ Thyroid problems
____ ____ Subnormal body temperature
____ ____ Cold when others are warm
____ ____ Thinning hair or eyebrows
____ ____ Difficulty losing weight
____ ____ Underweight, difficulty gaining weight
____ ____ Light bothers eyes
____ ____ Crave salt
____ ____ Dizzy on standing up
____ ____ Can't relax to go to sleep
____ ____ Diabetes
____ ____ Excessive thirst
____ ____ Hypoglycemia

____ ____ Headaches or Migraines
____ ____ Dizziness / Vertigo
____ ____ Fainting
____ ____ Seizures
____ ____ Paralysis
____ ____ Numbness/Loss of feeling
____ ____ Forgetfulness, poor memory
____ ____ Alzheimer's disease or dementia
____ ____ Confusion
____ ____ Mental fatigue, depression
____ ____ Jittery / anxious / irritable
____ ____ Poor digestion
____ ____ Poor appetite or excessive hunger
____ ____ Difficulty chewing or swallowing
____ ____ Reflux/ GERD or Hiatal Hernia
____ ____ Belching
____ ____ Intestinal gas
____ ____ Bitter or metallic taste in mouth
____ ____ Nausea
____ ____ Vomiting food
____ ____ Vomiting blood
____ ____ Stomach or abdominal pain
____ ____ Diarrhea
____ ____ Constipation
____ ____ Black or bloody stool
____ ____ Hemorrhoids
____ ____ Gallstones or gallbladder problems
____ ____ Hepatitis (Type?)
____ ____ Liver disease
____ ____ Jaundice

NOW PAST

_____ _____ Chest pain
_____ _____ Difficulty breathing
_____ _____ Difficulty breathing lying down
_____ _____ Persistent cough
_____ _____ Coughing blood
_____ _____ Respiratory Allergy
_____ _____ Asthma / Wheezing
_____ _____ Bronchitis
_____ _____ Pneumonia
_____ _____ Lung disease

_____ _____ Rapid or too slow heartbeat
_____ _____ Irregular heart beat
_____ _____ Palpitations, pounding heart beat
_____ _____ Mitral valve prolapse
_____ _____ Blood pressure problems
_____ _____ Heart disease
_____ _____ Pacemaker
_____ _____ Swelling ankles
_____ _____ Varicose veins
_____ _____ Stroke
_____ _____ Hardening of arteries
_____ _____ Bleeding disorder

_____ _____ Hearing loss
_____ _____ Ringing in ears / tinnitus
_____ _____ Ear ache or Ear discharge
_____ _____ Sinus infections or problems
_____ _____ Hay fever
_____ _____ Nose bleeds
_____ _____ Sore gums / mouth
_____ _____ Dental problems
_____ _____ Sore throat/ Tonsillitis
_____ _____ Hoarseness, Difficult speech

_____ _____ Glasses, Contacts
_____ _____ Bifocals
_____ _____ Eye strain
_____ _____ Double vision
_____ _____ Crossed eyes
_____ _____ Glaucoma
_____ _____ Retinal problems
_____ _____ Dry eyes

NOW PAST

_____ _____ Acne
_____ _____ Dry skin or Sensitive skin
_____ _____ Bruising easily
_____ _____ Eczema
_____ _____ Psoraisis
_____ _____ Vitiligo, loss of skin pigmentation
_____ _____ Hives
_____ _____ Skin allergy
_____ _____ Weak nails
_____ _____ Nail fungus