HEALTH QUESTIONNAI( )-HISTORY

Patient's Name

E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

○ **None** Of The Symptoms Listed Below	○ **No New** Symptoms Since Your Last Exam

- ○ General Fatigue
- ○ Weakness
- ○ Fever (continuous)
- ○ Loss Of Sleep
- ○ Chills (continuous)
- ○ Weight Change (unplanned)
- ○ Night Sweats

- ○ Headaches
- ○ Dizziness
- ○ Fainting
- ○ Convulsions
- ○ Nervousness

- ○ Anxiety
- ○ Depression (prolonged)
- ○ Phobias (excessive fears)
- ○ Memory Loss Or Impairment
- ○ Mood Swings (excessive)

	Left	Right
Hearing Trouble	○	○
Ringing in Ears	○	○
Pain in Ears	○	○
Ear Discharge	○	○
Vision Trouble	○	○
Pain in Eyes	○	○
Eye Discharge	○	○

- ○ Nose/Sinus Pain
- ○ Excessive Drainage
- ○ Nose Bleeds (chronic)
- ○ Nasal Infections (chronic)
- ○ Absence Of Smell

- ○ Mouth Sores
- ○ Bleeding Gums
- ○ Enlarged Glands
- ○ Absence Of Taste
- ○ Abnormal Taste Sensation
- ○ Tonsillitis/Infected Tonsils
- ○ Difficulty With Swallowing

- ○ Heat/Cold Intolerance
- ○ Sugar In Urine
- ○ Goiter (enlargedThyroid gland)
- ○ Tremor (shaking)

- ○ Skin Rash
- ○ Redness Of Skin
- ○ Skin Itching
- ○ Skin Dryness
- ○ Eczema(red, inflamed skin)
- ○ Hair Changes (unplanned)
- ○ Nail Changes (unplanned)
- ○ Bruise Easily

- ○ Cough (chronic)
- ○ Wheezing (chronic)
- ○ Difficulty Breathing
- ○ Swollen Extremities
- ○ Blue Extremities
- ○ Varicosities (visible veins)
- ○ Rapid Heart Beat
- ○ Chest Pain
- ○ Heart Palpitations
- ○ Heart Murmur

- ○ Decreased Appetite
- ○ Increased Appetite
- ○ Abdominal Pain
- ○ Hemorrhoids
- ○ Excess Gas
- ○ Vomiting (excessive)
- ○ Diarrhea (excessive)
- ○ Constipation (excessive)
- ○ Heartburn/Indigestion

- ○ Painful Urination
- ○ Inability To Hold Urine
- ○ Frequent Urination
- ○ Urinary Retention
- ○ Bed-wetting
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding
- ○ Sterility
- ○ Impotence

- ○ Lumps In Breast(s)
- ○ Redness/Itching of Breast
- ○ Dimpling of Breast(s)
- ○ Discharge from Breast(s)
- ○ Breast Pain

○ Other (Please Describe)

F. HABITS/ACTIVI S

What Are Your Current Habits?

	Never	<1	1-2	2-3	3-4	5+
		Packs Per Day				
Smoking	○	○	○	○	○	○
		Glasses Per Day				
Caffeinated Drinks	○	○	○	○	○	○
		Glasses Per Day				
Alcohol Consumption	○	○	○	○	○	○

	No	Yes
Drug/Substance Abuse	○	○

If Yes, Discuss With Doctor

	Never	<1	1-2	2-3	3-4	5+
		Days Per Week				
Exercise	○	○	○	○	○	○

Kinds Of Exercise You Do:

○ Walking ○ Jogging ○ Cycling ○ Swimming
○ Golf ○ Tennis ○ Strength Training
○ Other: _____

G. 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: _____
Phone:( )

c. Have You Been Hospitalized In The Past? Yes ○ No ○

Date & Reason For Hospitalization: _____

d. Have You Ever Had Surgery? Yes ○ No ○

Date, Reason, Results Of Surgery: _____

e. Have You Ever Had A Serious Accident/Injury? Yes ○ No ○

List Date & Describe Injury:

○ Auto: _____
○ Work-Related: _____
○ Personal: _____
○ Sports Injury: _____
○ Other: _____

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements) Yes ○ No ○

_____

g. Are You Currently Taking Any Medications? Yes ○ No ○

For What Condition(s) Are You Taking Medication?

○ Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.): _____
○ Pain/Analgesics: _____
○ Anti-Depressants: _____
○ Muscle Relaxants: _____
○ Blood Pressure Pills: _____
○ Antibiotics: _____
○ Birth Control Pills: _____
○ Corticosteroid: _____
○ Other: _____

In The Past Have You Use Any Of The Following?

○ Birth Control Pills ○ Corticosteroid

h. Are You Allergic To Any Medications? Yes ○ No ○

List Medications: _____

G. MEDICAL HISTORY - CONTINUED

1i. WOMEN ONLY:

	Yes	No
To Your Knowledge, Are You Pregnant?	○	○
If Pregnant In Past, Were Pregnancies Normal?	○	○
Are You Seeing An OB-GYN Regularly?	○	○

Number Of Births: ① ② ③ ④ ⑤ ○ Other:

Date Of Last Exam:

Physician's Name:

Address:

Phone: ( )

2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased?
Father	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	D
Mother	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	D
Brothers	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	
Sisters	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	
Children	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	

Describe Others:

3. Conditions Or Illnesses

Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:

○ *No Current Or Previous Conditions/Illnesses*

Now Have	In Past		Now Have	In Past	
H	P	Sinus Trouble	H	P	Kidney Trouble
H	P	Hay Fever	H	P	Urinary Retention
H	P	Allergies	H	P	Frequent Urination
H	P	Asthma	H	P	Prostate Trouble
H	P	Emphysema	H	P	Arthritis
H	P	Tuberculosis	H	P	Osteoporosis
H	P	History of Infection	H	P	Scoliosis
H	P	Fever (Continuous)	H	P	Dislocated Joints
H	P	Cancer/Tumor	H	P	Spinal Disc Disease
H	P	Diabetes	H	P	Bone Fracture (list/dates):
H	P	Visual Disturbances			
H	P	Dizziness/Fainting			
H	P	Epilepsy/Seizures			
H	P	Thyroid Trouble	H	P	Mental/Emotional Difficulty
H	P	High Blood Pressure	H	P	Sex. Trans. Diseases
H	P	Low Blood Pressure	H	P	HIV
H	P	Heart Trouble	H	P	AIDS/ARC
H	P	Pacemaker	H	P	Abnormal Weight Gain
H	P	Stroke [date_____]	H	P	Abnormal Weight Loss
H	P	Aortic Aneurysm	H	P	Numbness Groin/Buttocks
H	P	Anemia	H		Other:
H	P	Rheumatic Fever			
H	P	Polio		P	Other:
H	P	Multiple Sclerosis			
H	P	Ulcer			
H	P	Liver Trouble			

H. 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 Above Skip Rest, Sign At Patient's Signature

○ Full Time ○ Part Time ○ Temporary

○ Self-Employed ○ Other

3. During Your Work Week, You Work How Many:

Hours Per Day ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫

Days Per Week ① ② ③ ④ ⑤ ⑥ ⑦

○ Other

4. How Long Have You Been With Your Present Employer?

Years ⑩ ⑳ ㉚ ㊵ ㊿ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Months ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪

5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day? ○ Yes ○ No

6. What Is Your Primary Work Position and Location?

a. Work Position: ○ Seated ○ Standing ○ Other

b. Work Location: ○ Desk ○ Counter ○ Workbench ○ Other

7. What Movements Does Your Job Require?

○ Bending ○ Turning ○ Stooping

○ Twisting ○ Walking ○ Repetitive Hand Use

○ Carrying ○ Other

8. Does Your Work Include Any Of The Following Use?

○ Prolonged Computer ○ Continuous Phone

9. Does Your Job Involve Lifting?

○ Never ○ Occasionally ○ Intermittently

○ Frequently ○ Constantly

How Many Pounds? (Choose Only One) 10 20 30 40 50 60 70 80 90 100+ Pounds

10. What Best Describes Your Stress Level At Work?

○ None ○ Minimal ○ Minimal To Moderate

○ Moderate ○ Moderate To Extreme ○ Extreme

11. How Do You Rate Your Physical Activity At Work?

○ Seated more than 50% of workday

Manual Labor: ○ Light ○ Light To Moderate ○ Moderate ○ Moderate To Heavy ○ Heavy

12. Do Work Activities Aggravate Your Present Complaints?

○ Yes ○ No **If Yes, Explain:**

PATIENT'S SIGNATURE X **DATE:**

596136

PLEASE MAKE NO MARKS IN THIS AREA