

# HEALTH QUESTIONNAIRE

**Dear Patient:** Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **THANK YOU.**

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: . **Erase** changes cleanly. **Do not fold** this form.

Patient Name: \_\_\_\_\_  
 MO DAY YEAR DR# PATIENT NUMBER

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 0
<input type="radio"/> 10	<input type="radio"/> 11	<input type="radio"/> 12	<input type="radio"/> 13	<input type="radio"/> 14	<input type="radio"/> 15	<input type="radio"/> 16	<input type="radio"/> 17	<input type="radio"/> 18	<input type="radio"/> 19
<input type="radio"/> 20	<input type="radio"/> 21	<input type="radio"/> 22	<input type="radio"/> 23	<input type="radio"/> 24	<input type="radio"/> 25	<input type="radio"/> 26	<input type="radio"/> 27	<input type="radio"/> 28	<input type="radio"/> 29
<input type="radio"/> 30	<input type="radio"/> 31	<input type="radio"/> 32	<input type="radio"/> 33	<input type="radio"/> 34	<input type="radio"/> 35	<input type="radio"/> 36	<input type="radio"/> 37	<input type="radio"/> 38	<input type="radio"/> 39
<input type="radio"/> 40	<input type="radio"/> 41	<input type="radio"/> 42	<input type="radio"/> 43	<input type="radio"/> 44	<input type="radio"/> 45	<input type="radio"/> 46	<input type="radio"/> 47	<input type="radio"/> 48	<input type="radio"/> 49
<input type="radio"/> 50	<input type="radio"/> 51	<input type="radio"/> 52	<input type="radio"/> 53	<input type="radio"/> 54	<input type="radio"/> 55	<input type="radio"/> 56	<input type="radio"/> 57	<input type="radio"/> 58	<input type="radio"/> 59
<input type="radio"/> 60	<input type="radio"/> 61	<input type="radio"/> 62	<input type="radio"/> 63	<input type="radio"/> 64	<input type="radio"/> 65	<input type="radio"/> 66	<input type="radio"/> 67	<input type="radio"/> 68	<input type="radio"/> 69
<input type="radio"/> 70	<input type="radio"/> 71	<input type="radio"/> 72	<input type="radio"/> 73	<input type="radio"/> 74	<input type="radio"/> 75	<input type="radio"/> 76	<input type="radio"/> 77	<input type="radio"/> 78	<input type="radio"/> 79
<input type="radio"/> 80	<input type="radio"/> 81	<input type="radio"/> 82	<input type="radio"/> 83	<input type="radio"/> 84	<input type="radio"/> 85	<input type="radio"/> 86	<input type="radio"/> 87	<input type="radio"/> 88	<input type="radio"/> 89
<input type="radio"/> 90	<input type="radio"/> 91	<input type="radio"/> 92	<input type="radio"/> 93	<input type="radio"/> 94	<input type="radio"/> 95	<input type="radio"/> 96	<input type="radio"/> 97	<input type="radio"/> 98	<input type="radio"/> 99

Date Of Birth \_\_\_\_\_  
 Social Security # \_\_\_\_\_

Patient's Home Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_ FAX \_\_\_\_\_

Employer Business Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_

Referred By \_\_\_\_\_

Spouse Name \_\_\_\_\_  
 Social Security # \_\_\_\_\_

**Sex:**  
 Male  
 Female

**Marital Status:**  
 Single  
 Married  
 Widowed  
 Divorced  
 Other

**Patient Resides With:**  
 Lives Alone  Spouse  Parents  
 Children  Other

**Children:**  0  1  2  3  4  5+

## B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

### 1. a. GENERAL

Normal  Chills  
 Fatigue  Weight Change  
 Weakness  Night Sweats  
 Fever  Other

### b. SKIN

Normal  Eczema  
 Rash  Hair Changes  
 Redness  Nail Changes  
 Itching  Other

### c. NEUROLOGIC

Normal  Fainting  
 Headache  Convulsions  
 Dizziness  Other

### d. EYES

Normal  Right  Left  
 Vision Trouble    
 Pain    
 Discharge    
 Other

### e. EARS

Normal  Right  Left  
 Hearing Trouble    
 Ringing    
 Pain    
 Discharge    
 Other

### f. NOSE

Normal  Absence Of Smell  
 Pain  Other  
 Bleeding

### g. MOUTH/THROAT

Normal  Absence Of Taste  
 Sores  Abnormal Taste  
 Bleeding  Other

### h. HEART/LUNGS

Normal  Blue Extremities  
 Cough  Murmur  
 Wheezing  Chest Pain  
 Difficulty Breathing  Palpitations  
 Swollen Extremities  Other

### i. BREASTS

Normal  Dimpling  
 Lumps In Breast(s)  Discharge  
 Redness/Itching  Other  
 Pain

### j. STOMACH/INTESTINES

Normal  Vomiting  
 Decreased Appetite  Diarrhea  
 Increased Appetite  Constipation  
 Abdominal Pain  Other

### k. REPRODUCTIVE/URINATION

Normal  Impotence  
 Inability To Hold Urine  Sterility  
 Painful Urination  Other  
 Frequent Urination  
 Irregular Menstruation  
 Painful Menstruation  
 Abnormal Vaginal Bleeding

### l. GLANDULAR

Normal  Goiter  
 Heat/Cold Intolerance  Tremor  
 Sugar In Urine  Other

### m. MENTAL

Normal  Phobias  
 Anxiety  Mood Swings  
 Depression  Other  
 Memory Loss or Impairment

## A. MAJOR COMPLAINTS

### 1. What are your major complaints?

<input type="radio"/> None	<b>Pain</b>	<b>Numbness</b>	<b>Tingling</b>
Head	<input type="radio"/> H	<input type="radio"/> H	<input type="radio"/> H
Neck	<input type="radio"/> N	<input type="radio"/> N	<input type="radio"/> N
Upper Back	<input type="radio"/> U	<input type="radio"/> U	<input type="radio"/> U
Mid Back	<input type="radio"/> M	<input type="radio"/> M	<input type="radio"/> M
Lower Back	<input type="radio"/> L	<input type="radio"/> L	<input type="radio"/> L
	<b>R</b>	<b>L</b>	<b>R</b>
	<b>L</b>	<b>R</b>	<b>L</b>
Shoulder	<input type="radio"/> S	<input type="radio"/> S	<input type="radio"/> S
Arm	<input type="radio"/> A	<input type="radio"/> A	<input type="radio"/> A
Forearm	<input type="radio"/> F	<input type="radio"/> F	<input type="radio"/> F
Hand	<input type="radio"/> H	<input type="radio"/> H	<input type="radio"/> H
Buttock	<input type="radio"/> B	<input type="radio"/> B	<input type="radio"/> B
Hip	<input type="radio"/> H	<input type="radio"/> H	<input type="radio"/> H
Thigh	<input type="radio"/> T	<input type="radio"/> T	<input type="radio"/> T
Leg	<input type="radio"/> L	<input type="radio"/> L	<input type="radio"/> L
Foot	<input type="radio"/> F	<input type="radio"/> F	<input type="radio"/> F

### 2. Currently your pain is aggravated by

Coughing  Lifting  
 Sneezing  Bending  
 Straining At Stool  Sitting  
 Neck Movement  Standing  
 Reaching  Walking  
 Other

### 3. Since your symptoms began, have you noticed a change in

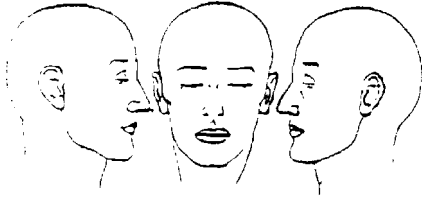
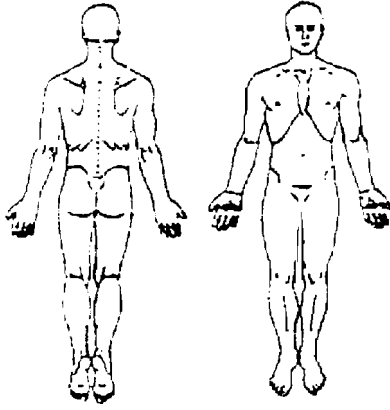
Bowel Function  Bladder Function  
 Ability To Maintain An Erection

**2. What are your habits?**

		Never	Occasionally	Moderately	Excessively
Smoking	(S)	(S)	(S)	(S)	(S)
Alcohol	(A)	(A)	(A)	(A)	(A)
Recreational Drugs	(R)	(R)	(R)	(R)	(R)
Exercise	(E)	(E)	(E)	(E)	(E)

**C. PAIN DIAGRAMS**

Please mark the location of your pain on these figures



**D. MEDICAL HISTORY**

**1. HEALTH CARE**

	Yes	No
a. Have you been to a chiropractor .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you have a family physician .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>c. WOMEN:</b>		
To the best of your knowledge are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the regular care of an OB-GYN . . .	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you been hospitalized in the past five years	<input type="checkbox"/>	<input type="checkbox"/>
e. Are you currently taking any medication .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anti-inflammatory (Aspirin, Motrin, etc.)		
<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Pain Medication/Analgesic	
<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Birth Control Pills	
<input type="checkbox"/> Other		

**2. Which of the following illnesses have you had?**

*No Previous Conditions/Illnesses*

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Polio
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Serious Injury
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bone Fracture
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dislocated Joints
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Spinal Disc Disease
<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Mental/Emotional Difficulty
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> AIDS	<input type="checkbox"/> Other
<input type="checkbox"/> Sexually Transmitted Disease	

**3. FAMILY HISTORY**

		Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)
Mother	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)
Brothers	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)
Sisters	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)
Children	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)

**E. INSURANCE INFORMATION**

	Yes	No
1. Is your condition due to an automobile accident .....	<input type="checkbox"/>	<input type="checkbox"/>
Date of Accident		
Have You filed an accident report .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Is your condition due to a job injury .....	<input type="checkbox"/>	<input type="checkbox"/>
Date of Injury		
Have You filed an injury report .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have health insurance .....	<input type="checkbox"/>	<input type="checkbox"/>
Company		
Policy #		
4. Are you covered by Medicare .....	<input type="checkbox"/>	<input type="checkbox"/>
Medicare #		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

**F. PAYMENT**

I WILL BE PAYING TODAY BY:

Cash     Check     Credit Card

MasterCard     Visa     American Express

Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

**All accounts not paid within 90 days will automatically be put through on your credit card.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_