HEALTH QUESTIONNAIRE

—PLEASE PRINT—

TO SAVE TIME AND TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS

NAME		**REFERRED BY**	
COMPLETE ADDRESS		DOB	AGE
HOME PHONE	WORK PHONE	CELL PHONE	
EMAIL	BEST WAY TO CONTACT YOU	BEST TIME	
☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED	NO. OF CHILDREN	NAMES/AGES OF CHILDREN	
OCCUPATION	EMPLOYER	EMPLOYER ADDRESS	
PLEASE INDICATE IF YOU ARE HERE FOR CARE BECAUSE OF: ☐ ON THE JOB INJURY ☐ AUTO INJURY ☐ HOME INJURY ☐OTHER			
PLEASE EXPLAIN:			
SOCIAL SECURITY NUMBER	HAVE YOU HAD CHIROPRACTIC CARE BEFORE? ☐ YES ☐ NO IF YES, WHERE? WHEN?		
WHAT BRINGS YOU IN TODAY?	HOW LONG HAS IT BEEN BOTHERING YOU?	HAS IT BOTHERED YOU BEFORE?	
DO YOU HAVE HEALTH INSURANCE? ☐ YES, COMPANY ☐ NO	ARE YOU ON MEDICARE? ☐ YES, # _____ ☐ NO	ARE YOU ON MEDICAID? ☐ YES, # _____ ☐ NO	
ARE YOU ON A REIMBURSING INSURANCE? ☐ YES, COMPANY ☐ NO	SPOUSE'S NAME & INSURANCE		
SPOUSE'S DATE OF BIRTH	SPOUSE'S SOCIAL SECURITY NUMBER		
HAVE YOU EVER HAD ANY FALLS, AUTO ACCIDENTS OR INJURIES? ☐ YES, PLEASE EXPLAIN ☐ NO	PLEASE PROVIDE MO/YR, TYPE OF ACCIDENT AND DESCRIBE INJURY.		
HAVE YOU EVER HAD SURGERY? ☐ YES, PLEASE EXPLAIN ☐ NO	PLEASE PROVIDE MO/YR, TYPE OF SURGERY AND ANY OTHER COMMENTS.		
ARE YOU PRESENTLY TAKING ANY MEDS OR VITAMINS? ☐ YES, PLEASE EXPLAIN ☐ NO	PLEASE PROVIDE THE NAME, DOSAGE & DURATION FOR EACH.		
LIST ANY SPORTS/EXERCISE PROGRAMS	DO YOU DRINK ALCOHOL?_____AMT/WK _____ DO YOU SMOKE? _____ PACKS PER DAY _____		

PATIENT'S SIGNATURE: _____DATE _____

— PLEASE SEE OTHER SIDE—

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY OR YOU HAVE HAD RECENTLY.

- ☐ HEADACHES 784.0
- ☐ SHOOTING HEAD PAINS 784.0
- ☐ SINUS TROUBLE 473.9
- ☐ LOSS OF SMELL 781.1
- ☐ ALLERGIES 995.3
- ☐ HAYFEVER 477.8
- ☐ ASTHMA 493.9
- ☐ LOSS OF TASTE 781.1
- ☐ INFLAM. OF THROAT 462.0
- ☐ THYROID TROUBLE 246.9
- ☐ FACE TWITCH 351.9
- ☐ FATIGUE 780.7
- ☐ DEPRESSION 311.0
- ☐ DIZZINESS 780.4
- ☐ SPINAL CURVATURE 737.43
- ☐ CHEST PAIN 786.5
- ☐ FAINTING 780.2
- ☐ LOSS OF BALANCE 781.2
- ☐ RINGING IN EARS 388.3
- ☐ BLURRED VISION 368.0
- ☐ LIGHTS HURT EYES 368.13
- ☐ NECK PAIN 723.1
- ☐ MUSCLE SPASM NECK 781.0
- ☐ GRINDING IN NECK 719.68
- ☐ TIGHT SHOULDER & ARM 728.85
- ☐ PAIN IN SHOULDER/ARM 719.4
- ☐ PINS/NEEDLES IN ARMS/HANDS 782.0
- ☐ COLD HANDS 782.0
- ☐ NUMBNESS IN ARM/HAND 782.0
- ☐ COLD HAND/FINGERS 782.0
- ☐ TONSILITIS 784.0
- ☐ PROSTATE TROUBLE 601.4
- ☐ SHORTNESS OF BREATH 786.09
- ☐ MID-BACK PAIN 724.1
- ☐ HEART ATTACK 410.9
- ☐ HIGH BLOOD PRESSURE 401.9
- ☐ LOW BLOOD PRESSURE 458.9
- ☐ ANEMIA 285.9
- ☐ STOMACH TROUBLE 789.0
- ☐ NERVES/NERVOUSNESS 799.2
- ☐ INNER TENSION 799.2
- ☐ IRRITABILITY 799.2
- ☐ GALL BLADDER TROUBLE 575.9
- ☐ INDIGESTION 536.8
- ☐ INTESTINAL GAS 787.3
- ☐ LOW BACK PAIN 724.2
- ☐ HERNIA 550.01
- ☐ STROKE 436.0
- ☐ BED WETTING 788.3
- ☐ ULCERS 534.9
- ☐ NUMBNESS OF LEGS/FEET 782.0
- ☐ CONSTIPATION 564.0
- ☐ KIDNEY TROUBLE 593.9
- ☐ MENSTRUAL CRAMP/PAIN 625.3
- ☐ MENSTRUAL IRREG. 626.4
- ☐ DIABETES 250.0
- ☐ SLEEPING PROBLEMS 780.5
- ☐ PAINFUL JOINTS 719.4
- ☐ SWOLLEN JOINTS 719.0
- ☐ PINS/NEEDLES IN LEG 782.0
- ☐ SWOLLEN ANKLES 782.3
- ☐ COLD FEET 782.0
- ☐ PAIN IN LEG/FEET 719.46
- ☐ HIP PAIN 719.45

FAMILY HISTORY SECTION

DO ANY OF YOUR CHILDREN HAVE ANY OF THE FOLLOWING?

NAME & AGE

HEADACHES	YES/NO _____
ALLERGIES	YES/NO _____
EAR INFECTIONS	YES/NO _____
FREQUENT COLDS	YES/NO _____
ASTHMA	YES/NO _____
CONSTANT IRRITABILITY	YES/NO _____
CONSTIPATION	YES/NO _____
GROWING PAINS	YES/NO _____
HYPER KINETIC	YES/NO _____
BLOODY NOSES	YES/NO _____
SCOLIOSIS	YES/NO _____
BEDWETTING	YES/NO _____

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING? IF YESS WHAT RELATION TO YOU-

DIABETES	YES/NO _____
CANCER	YES/NO _____
STROKE	YES/NO _____
HEART PROBLEMS	YES/NO _____
SCOLIOSIS	YES/NO _____
BACK PROBLEMS	YES/NO _____
HEADACHES	YES/NO _____
ULCERS	YES/NO _____

HAVE ALL YOUR CHILDREN HAD A SCOLIOSIS EXAM BY A CHIROPRACTOR? **YES/NO**

HAVE ANY OF YOUR RELATIVES BEEN EXAMINED BY A CHIROPRACTOR? **YES/NO**

DO ANY OF THE PEOPLE YOU WORK WITH HAVE THE SAME HEALTH PROBLEMS AS YOU? **YES/NO** IF YES, PLEASE EXPLAIN- _____

TO THE BEST OF YOUR KNOWLEDGE, ARE YOU PREGNANT, EITHER SUSPECTED OR CONFIRMED AT THIS PARTICLUAR TIME? **YES/NO**

** SERVICES ARE DUE AT TIME OF SERVICE. IF WE HAVE TO BILL YOU, A $5.00 FEE WILL APPLY.

** CONTACTING INSURANCE COMPANIES IS A COURTESY THAT WE DO FOR ALL PATIENTS, SOMETIMES WE ARE GIVEN THE WRONG OR INCOMPLETE INFORMATION. IF THIS HAPPENS, ANY OVER PAYMENTS WILL BE GIVEN IN THE FORM OF A CREDIT TOWARDS YOUR CARE. WE ADVISE THAT YOU ALSO CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS.

SIGNATURE _____ DATE _____