



# PATIENT HISTORY QUESTIONNAIRE

(For Chiropractic and Functional Medicine Patients)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

S.S.N. \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Are you interested in receiving our newsletter?  Yes  No

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

May we communicate our findings with your medical doctor?  Yes  No

**Whom may we thank for referring you?** \_\_\_\_\_

List, in order of importance, your Primary Medical Issues

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

List, in order of importance, other Medical Issues you may be seeing other providers for: (List issue & provider)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Have you ever had x-rays?:  Yes  No If Yes, date of last x-ray: \_\_\_\_\_ For what \_\_\_\_\_

Have you ever had MRI's?:  Yes  No If Yes, date of last MRI: \_\_\_\_\_ For what \_\_\_\_\_

Have you ever had other tests/studies?:  Yes  No If yes, list below:

1. Date: _____	Study/Test: _____	Treatment received: _____
2. Date: _____	Study/Test: _____	Treatment received: _____
3. Date: _____	Study/Test: _____	Treatment received: _____

Have you seen any other providers for your presenting complaint(s) today?  Yes  No  
 If yes, list their name and specialty: \_\_\_\_\_

What types of treatment(s) have you received, if any, for your presenting condition(s)? \_\_\_\_\_

Do you have any known allergies or drug allergies? \_\_\_\_\_

What medications and dosages are you currently taking? \_\_\_\_\_

Please mark with an "x" the following that you have taken in the past 2 months:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> vitamins            | <input type="checkbox"/> beta blockers       | <input type="checkbox"/> hormone replacements |
| <input type="checkbox"/> herbs               | <input type="checkbox"/> muscle relaxers     | <input type="checkbox"/> appetite curb pills  |
| <input type="checkbox"/> laxatives           | <input type="checkbox"/> pain medicine       | <input type="checkbox"/> thyroid medication   |
| <input type="checkbox"/> stomach/GI/reflux   | <input type="checkbox"/> cold/cough medicine | <input type="checkbox"/> insulin              |
| <input type="checkbox"/> birth control pills |  |   |

Is your current condition related to a work injury or an automobile accident?  Yes  No

If yes, which one? \_\_\_\_\_

Have you ever been in an automobile accident?  past year  past 5 years  over 5 years ago  never

Have you ever sustained a work injury for which you received treatment?  Yes  No

If yes, when? \_\_\_\_\_

Please check the following conditions that you have or have had:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> AIDS                      | <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Rheumatic fever      |
| <input type="checkbox"/> Acid reflux               | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Low blood sugar          | <input type="checkbox"/> Venereal disease     |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Multiple sclerosis       | <input type="checkbox"/> Yeast Infection      |
| <input type="checkbox"/> Crohn's disease           | <input type="checkbox"/> Parkinson's disease      | <input type="checkbox"/> Hyperthyroidism      |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Polio                    | <input type="checkbox"/> Hashimoto's Syndrome |
| <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Ulcerative Colitis       | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Hardening of the arteries | <input type="checkbox"/> Autoimmune Diseases      |   |

#### Head

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Unusually frequent headaches | <input type="checkbox"/> Facial numbness  | <input type="checkbox"/> Loss of taste        |
| <input type="checkbox"/> Unusually severe headaches   | <input type="checkbox"/> Light-headedness | <input type="checkbox"/> Loss of balance      |
| <input type="checkbox"/> Head feels heavy             | <input type="checkbox"/> Loss of smell    | <input type="checkbox"/> Previous head trauma |
| <input type="checkbox"/> Vertigo                      |   |   |

#### Neck

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Neck pain with movement | <input type="checkbox"/> Pinched nerve in neck        | <input type="checkbox"/> Muscle spasms in neck   |
| <input type="checkbox"/> Swelling in neck        | <input type="checkbox"/> Dizziness with neck movement | <input type="checkbox"/> Abnormal sounds in neck |
| <input type="checkbox"/> Stiff neck              | <input type="checkbox"/> Neck feels out of place      | <input type="checkbox"/> Previous neck injury    |

#### Shoulders

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pain in shoulder (right or left) | <input type="checkbox"/> Tension in shoulders       | <input type="checkbox"/> Can't raise arm above shoulder |
| <input type="checkbox"/> Pain across shoulders            | <input type="checkbox"/> Muscle spasms in shoulders | <input type="checkbox"/> Can't raise arm over head      |

#### Arms & Hands

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pain in upper arm | <input type="checkbox"/> Fingers go to sleep           | <input type="checkbox"/> Cold hands            |
| <input type="checkbox"/> Pain in forearm   | <input type="checkbox"/> Sensation of pins and needles | <input type="checkbox"/> Swollen finger joints |
| <input type="checkbox"/> Pain in hands     | <input type="checkbox"/> _____ in arms                 | <input type="checkbox"/> Sore finger joints    |
| <input type="checkbox"/> Pain in fingers   | <input type="checkbox"/> _____ in fingers              | <input type="checkbox"/> Loss of grip strength |

#### Mid Back

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pain between shoulder blades | <input type="checkbox"/> Pain from front to back | <input type="checkbox"/> Muscle spasms in mid back                  |
| <input type="checkbox"/> Mid back pain                | <input type="checkbox"/> Pain over kidney area   | <input type="checkbox"/> Pain below shoulder blades (with exercise) |

#### Low Back

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Low back feels out of place | <input type="checkbox"/> Muscle spasms in low back |
|--|--|--|

#### Hips, Legs, & Feet

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pain in buttocks | <input type="checkbox"/> Sensation of pins and needles | <input type="checkbox"/> Cold feet      |
| <input type="checkbox"/> Pain down leg    | <input type="checkbox"/> Numbness in legs              | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Knee pain        | <input type="checkbox"/> Numbness in toes              | <input type="checkbox"/> Swollen feet   |
| <input type="checkbox"/> Leg cramps       |  |   |

#### Cardiovascular

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> General swelling     | <input type="checkbox"/> Heart "jumps"       | <input type="checkbox"/> Poor circulation         |
| <input type="checkbox"/> Swelling in legs     | <input type="checkbox"/> Rapid heartbeat     | <input type="checkbox"/> Heart murmurs            |
| <input type="checkbox"/> Swelling in face     | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Difficulty laying flat   |
| <input type="checkbox"/> Swelling around eyes | <input type="checkbox"/> Blue or purple skin | <input type="checkbox"/> Chest pain with exercise |
| <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Pacemaker                |
| <input type="checkbox"/> Pounding heartbeat   | <input type="checkbox"/> High blood pressure |   |

#### Hair, Skin, & Nails

- |                                   |   |                                 |
|-----------------------------------|---|---------------------------------|
| <input type="checkbox"/> Baldness | <input type="checkbox"/> Rough, scaly scalp | <input type="checkbox"/> Rashes |
|-----------------------------------|---|---------------------------------|

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Dry scalp  | <input type="checkbox"/> Dry skin Oily | <input type="checkbox"/> Skin cancer                   |
| <input type="checkbox"/> Oily scalp | <input type="checkbox"/> skin Yellow   | <input type="checkbox"/> Sensitive skin                |
| <input type="checkbox"/> Eczema     | <input type="checkbox"/> skin Bruise   | <input type="checkbox"/> Paper thin nails              |
| <input type="checkbox"/> Psoriasis  | <input type="checkbox"/> easily Pale   | <input type="checkbox"/> Nail biting                   |
| <input type="checkbox"/> Itchy skin | <input type="checkbox"/> skin          | <input type="checkbox"/> Allergies to Chlorine/Bromine |

#### Eyes

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Blurred vision      | <input type="checkbox"/> Lack of tearing    | <input type="checkbox"/> Periods of blindness in eye(s) |
| <input type="checkbox"/> Double vision       | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Red eyes                       |
| <input type="checkbox"/> Eyes fatigue easily | <input type="checkbox"/> Excessive itching  | <input type="checkbox"/> Night blindness                |
| <input type="checkbox"/> Excessive tearing   | <input type="checkbox"/> Pain in eyeball(s) | <input type="checkbox"/> Pain behind eyes               |

#### Ears

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Discharge from ears | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Pain in ears    | <input type="checkbox"/> Vertigo             |  |

#### Nose/Nasopharynx/Sinuses

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Unusual nasal discharge | <input type="checkbox"/> Frequent colds      | <input type="checkbox"/> Loss sense of smell |
| <input type="checkbox"/> Nose bleeds             | <input type="checkbox"/> Obstruction of nose | <input type="checkbox"/> Any trauma to nose  |
| <input type="checkbox"/> Pressure over eyes      | <input type="checkbox"/> Sinusitis           |  |
| <input type="checkbox"/> Pressure under eyes     | <input type="checkbox"/> Nasal allergies     |  |

#### Mouth & Throat

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Pain in mouth  | <input type="checkbox"/> Cavities        | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Pain in throat | <input type="checkbox"/> Abscessed teeth | <input type="checkbox"/> Changes in voice      |
| <input type="checkbox"/> Bleeding gums  | <input type="checkbox"/> Dentures        |  |

#### Respiratory

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Shortness of breath                   | <input type="checkbox"/> Dry cough                            | <input type="checkbox"/> Coughing up blood    |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Difficulty sleeping while lying down | <input type="checkbox"/> Wheezing             |
| <input type="checkbox"/> Chronic cough                         | <input type="checkbox"/> Productive cough                     | <input type="checkbox"/> Abnormal chest x-ray |
| <input type="checkbox"/> Difficulty breathing while lying down |   |   |

#### Gastrointestinal

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Poor appetite                 | <input type="checkbox"/> Stomach gas before meals | <input type="checkbox"/> Loss of bowel control |
| <input type="checkbox"/> Constant nibbling             | <input type="checkbox"/> Stomach gas with meals   | <input type="checkbox"/> Jaundice              |
| <input type="checkbox"/> Indigestion                   | <input type="checkbox"/> Stomach gas after meals  | <input type="checkbox"/> Liver disease         |
| <input type="checkbox"/> Stomach upsets from food      | <input type="checkbox"/> Change in bowel habits   | <input type="checkbox"/> Hepatitis             |
| <input type="checkbox"/> Stomach upsets from liquid    | <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Gall bladder disease  |
| <input type="checkbox"/> Stomach upsets from medicines | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Gall bladder removed  |
| <input type="checkbox"/> Abdominal pains               | <input type="checkbox"/> Hemorrhoids              | <input type="checkbox"/> Abdominal bloating    |
| <input type="checkbox"/> Gall bladder removed          | <input type="checkbox"/> Ulcers                   |  |

#### Genitourinary

- |  |   |   |
|--|---|---|
| Urination is <input type="checkbox"/> Frequent <input type="checkbox"/> Infrequent | <input type="checkbox"/> Dribbling      |   |
| <input type="checkbox"/> Need to get up at night to urinate                        | <input type="checkbox"/> Incontinence   | <input type="checkbox"/> Lack of bladder control  |
| <input type="checkbox"/> Difficult to start/stop urination                         | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Back pain with urination |
| <input type="checkbox"/> Painful urination   | <input type="checkbox"/> Cloudy urine   | <input type="checkbox"/> Stream flow abnormality  |

#### Female Only

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Painful periods          | _____ No. of deliveries                         | _____ Date of last menstrual period               |
| <input type="checkbox"/> Missed menstrual periods | _____ No. of vaginal deliveries                 | <input type="checkbox"/> Excessive menstrual flow |
| <input type="checkbox"/> Irregular cycles         | _____ No. of C-sections                         | <input type="checkbox"/> PMS symptoms             |
| <input type="checkbox"/> Spotting                 | <input type="checkbox"/> Complicated deliveries | <input type="checkbox"/> Hormone contraceptive    |
| <input type="checkbox"/> Vaginal discharge        | <input type="checkbox"/> LBP w/menses           | <input type="checkbox"/> Fertility treatment      |
| <input type="checkbox"/> Miscarriage              | <input type="checkbox"/> LBP w/pregnancy        | <input type="checkbox"/> Abnormal pap test        |
| <input type="checkbox"/> Premenstrual symptoms    | <input type="checkbox"/> Fibroid tumors         | <input type="checkbox"/> Vaginal infection        |
| <input type="checkbox"/> Lumps in breasts         | <input type="checkbox"/> Ovarian cysts          | <input type="checkbox"/> Endometriosis            |
| <input type="checkbox"/> Wear an IUD              | <input type="checkbox"/> Nipple discharges      | <input type="checkbox"/> PCOS                     |
| _____ No. of pregnancies                          | <input type="checkbox"/> Tubal pregnancy        |   |

**Male Only**

- Impotence
- Testicular swelling/pain
- Testicular masses
- Blood in sperm
- Prostate disease
- Premature ejaculation

**Cancer**

Do you have a history of cancer?  Yes  No

If yes, please describe: \_\_\_\_\_

**General Health Questions**

Do you use tobacco products?  Yes  No

If yes, indicate what kind, how much you use, and for how long you have use the products:

If you do not currently use tobacco, have you ever used the product?  Yes  No

If yes, describe what you used, how long did you use the product, and when did you quit:

Beverages: Please list how many drinks you have per week:

_____ Coffee _____ Tea _____ Beer	_____ Wine _____ Other Alcohol _____ Soda	_____ Water _____ Carbonated/sparkling water
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Is your history significant for recreational drug use?  Yes  No

If yes, describe:

How do you sleep?: <input type="checkbox"/> Well <input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Trouble staying asleep    Insomnia Do you wake up tired?: <input type="checkbox"/> Yes <input type="checkbox"/> No How long has this been happening? _____ My diet is: <input type="checkbox"/> Balanced <input type="checkbox"/> Not Balanced	My recreation is: <input type="checkbox"/> Sufficient <input type="checkbox"/> Not Sufficient My family stress is: <input type="checkbox"/> Severe      Moderate      Minimal      None How do you like your work: <input type="checkbox"/> Above average <input type="checkbox"/> Average <input type="checkbox"/> Below Average <input type="checkbox"/> N/A My job stress is: <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal <input type="checkbox"/> None <input type="checkbox"/> N/A
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How would you rate your stress level? (1 = low, 10 = extreme) \_\_\_\_\_

How would you rate your stress handling? (1 = poor, 10 = excellent) \_\_\_\_\_

How often do you exercise?  Never  Rarely  Sometimes  Regularly  Competitively

I have experienced:  Nervousness  Irritability  Fatigue  Depression  Run Down Feeling

Does your past history include any falls, head injuries, broken bones, hospitalizations or surgeries?  Yes  No

If yes, please elaborate on when, where, what, etc.:

Are you:  Single  Married  Divorced  Separated  Widowed (check one)

Do you have any children?  Yes  No

If yes, please list their sex and their ages:

Do your children have any major medical problems (past or present)?  Yes  No

If yes, please describe:

Do you have any siblings?  Yes  No

If yes, please list any major medical problems that are part of your siblings' history:

Are your parents still living?  Yes  No

Are there any major medical problems (past or present) that are part of their history?  Yes  No

If yes, please describe:

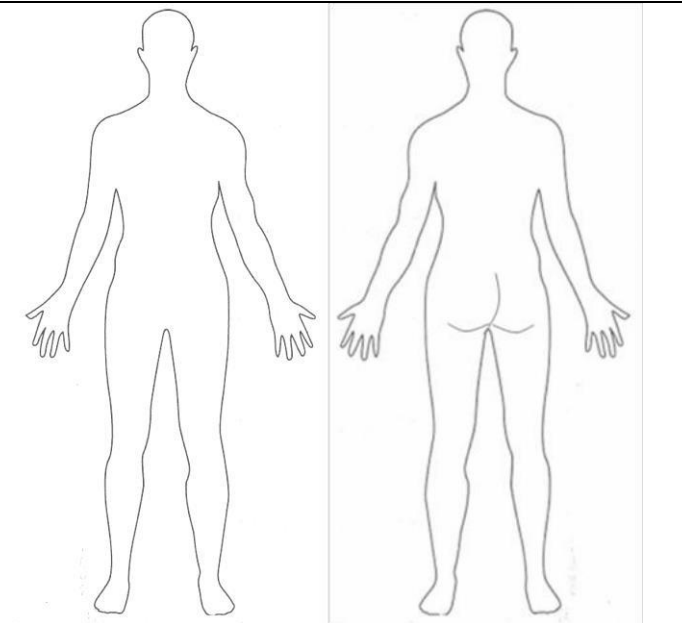
Do your maternal or paternal grandparents have any major medical problems (past or present) that are part of their history?  
 Yes  No

If yes, please describe: \_\_\_\_\_

1. What type of pain is it?  
 Sharp/stabbing  Ache  Dull  Burning  Throbbing  Numbness  Tingling  Cramping
2. Rate pain on a scale of 0 – 10 (10 being severe pain) \_\_\_\_  Average  Better  Worse  Over past week
3. How long have you had this pain? \_\_\_\_\_
4. What makes the pain worse? \_\_\_\_\_
5. What makes the pain better? \_\_\_\_\_
6. Does the pain travel?  Yes  No If so, where? \_\_\_\_\_
7. Is pain worse at any particular time of day? \_\_\_\_\_
8. Date of onset \_\_\_\_\_. Date of same or similar symptoms? \_\_\_\_\_

To help us better understand the nature & origin of your complaints, we ask that you carefully complete this drawing. Use the symbols listed below to detail where you hurt and how it hurts on the figures.

/// = Dull ache/throb  
xxx = Sharp/stabbing  
bbb = Burning  
ooo = numbness  
::: = Tingling  
ccc = Cramping



Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Thank you for completing this form. The information you have provided will assist us in attending to your healthcare needs. I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions may require me to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo care designed for me if determined to be clinically medically necessary by my doctor or therapist. I will notify them of any changes in my health status during the duration of the program. It is also my duty to daily inform the doctor, therapist or assistant of any possible complication prior to the initiation of my daily rehabilitation or treatment.

Your signature \_\_\_\_\_ Date \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Please Leave Blank:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_