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:

☐ vitamins	☐ beta blockers	☐ hormone replacements
☐ herbs	☐ muscle relaxers	☐ appetite curb pills
☐ laxatives	☐ pain medicine	☐ thyroid medication
☐ stomach/GI/reflux	☐ cold/cough medicine	☐ insulin
☐ 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:

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

Head

☐ Unusually frequent headaches	☐ Facial numbness	☐ Loss of taste Loss of
☐ Unusually severe headaches	☐ Light-headedness	☐ balance Previous head
☐ Head feels heavy	☐ Loss of smell	☐ trauma
☐ Vertigo		

Neck

☐ Neck pain with movement	☐ Pinched nerve in neck	☐ Muscle spasms in neck
☐ Swelling in neck	☐ Dizziness with neck movement	☐ Abnormal sounds in neck
☐ Stiff neck	☐ Neck feels out of place	☐ Previous neck injury

Shoulders

☐ Pain in shoulder (right or left)	☐ Tension in shoulders	☐ Can't raise arm above shoulder
☐ Pain across shoulders	☐ Muscle spasms in shoulders	☐ Can't raise arm over head

Arms & Hands

☐ Pain in upper arm	☐ Fingers go to sleep	☐ Cold hands
☐ Pain in forearm	☐ Sensation of pins and needles	☐ Swollen finger joints
☐ Pain in hands	☐ in arms	☐ Sore finger joints
☐ Pain in fingers	☐ in fingers	☐ Loss of grip strength

Mid Back

☐ Pain between shoulder blades	☐ Pain from front to back	☐ Muscle spasms in mid back
☐ Mid back pain	☐ Pain over kidney area	☐ Pain below shoulder blades (with exercise)

Low Back

☐ Low back pain	☐ Low back feels out of place	☐ Muscle spasms in low back

Hips, Legs, & Feet

☐ Pain in buttocks	☐ Sensation of pins and needles	☐ Cold feet
☐ Pain down leg	☐ Numbness in legs	☐ Swollen ankles
☐ Knee pain	☐ Numbness in toes	☐ Swollen feet
☐ Leg cramps		

Cardiovascular

☐ General swelling	☐ Heart "jumps"	☐ Poor circulation
☐ Swelling in legs	☐ Rapid heartbeat	☐ Heart murmurs Difficulty
☐ Swelling in face	☐ Irregular heartbeat	☐ laying flat Chest pain
☐ Swelling around eyes	☐ Blue or purple skin	☐ with exercise Pacemaker
☐ Chest pain	☐ Fainting	☐
☐ Pounding heartbeat	☐ High blood pressure	

Hair, Skin, & Nails

☐ Baldness	☐ Rough, scaly scalp	☐ Rashes

☐ Dry scalp	☐ Dry skin Oily	☐ Skin cancer
☐ Oily scalp	☐ skin Yellow	☐ Sensitive skin
☐ Eczema	☐ skin Bruise	☐ Paper thin nails
☐ Psoriasis	☐ easily Pale	☐ Nail biting
☐ Itchy skin	☐ skin	☐ Allergies to Chlorine/Bromine
Eyes		
☐ Blurred vision	☐ Lack of tearing	☐ Periods of blindness in eye(s)
☐ Double vision	☐ Light bothers eyes	☐ Red eyes
☐ Eyes fatigue easily	☐ Excessive itching	☐ Night blindness
☐ Excessive tearing	☐ Pain in eyeball(s)	☐ Pain behind eyes
Ears		
☐ Loss of hearing	☐ Discharge from ears	☐ Ringing in ears
☐ Pain in ears	☐ Vertigo	
Nose/Nasopharynx/Sinuses		
☐ Unusual nasal discharge	☐ Frequent colds	☐ Loss sense of smell
☐ Nose bleeds	☐ Obstruction of nose	☐ Any trauma to nose
☐ Pressure over eyes	☐ Sinusitis	
☐ Pressure under eyes	☐ Nasal allergies	
Mouth & Throat		
☐ Pain in mouth	☐ Cavities	☐ Difficulty swallowing
☐ Pain in throat	☐ Abscessed teeth	☐ Changes in voice
☐ Bleeding gums	☐ Dentures	
Respiratory		
☐ Shortness of breath	☐ Dry cough	☐ Coughing up blood
☐ Asthma	☐ Difficulty sleeping while lying down	☐ Wheezing
☐ Chronic cough	☐ Productive cough	☐ Abnormal chest x-ray
☐ Difficulty breathing while lying down		
Gastrointestinal		
☐ Poor appetite	☐ Stomach gas before meals	☐ Loss of bowel control
☐ Constant nibbling	☐ Stomach gas with meals	☐ Jaundice
☐ Indigestion	☐ Stomach gas after meals	☐ Liver disease
☐ Stomach upsets from food	☐ Change in bowel habits	☐ Hepatitis
☐ Stomach upsets from liquid	☐ Diarrhea	☐ Gall bladder disease
☐ Stomach upsets from medicines	☐ Constipation	☐ Gall bladder removed
☐ Abdominal pains	☐ Hemorrhoids	☐ Abdominal bloating
☐ Gall bladder removed	☐ Ulcers	
Genitourinary		
Urination is ☐ Frequent ☐ Infrequent	☐ Dribbling	
☐ Need to get up at night to urinate	☐ Incontinence	☐ Lack of bladder control
☐ Difficult to start/stop urination	☐ Blood in urine	☐ Back pain with urination
☐ Painful urination	☐ Cloudy urine	☐ Stream flow abnormality
Female Only		
☐ Painful periods	_____No. of deliveries	_____Date of last menstrual period
☐ Missed menstrual periods	_____No. of vaginal deliveries	☐ Excessive menstrual flow
☐ Irregular cycles	_____No. of C-sections	☐ PMS symptoms
☐ Spotting	☐ Complicated deliveries	☐ Hormone contraceptive
☐ Vaginal discharge	☐ LBP w/menses	☐ Fertility treatment
☐ Miscarriage	☐ LBP w/pregnancy	☐ Abnormal pap test
☐ Premenstrual symptoms	☐ Fibroid tumors	☐ Vaginal infection
☐ Lumps in breasts	☐ Ovarian cysts	☐ Endometriosis
☐ Wear an IUD	☐ Nipple discharges	☐ PCOS
_____No. of pregnancies	☐ Tubal pregnancy	

Male Only

☐ Impotence	☐ Testicular masses	☐ Prostate disease
☐ Testicular swelling/pain	☐ Blood in sperm	☐ 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	_____Wine	_____Water
_____Tea	_____Other Alcohol	_____Carbonated/sparkling water
_____Beer	_____Soda	

Is your history significant for recreational drug use? ☐ Yes ☐ No

If yes, describe:

_____

How do you sleep?: ☐ Well ☐ Trouble falling asleep ☐ Trouble staying asleep Insomnia Do you wake up tired?: ☐ Yes ☐ No How long has this been happening? _____ My diet is: ☐ Balanced ☐ Not Balanced	My recreation is: ☐ Sufficient ☐ Not Sufficient My family stress is: ☐ Severe ☐ Moderate ☐ Minimal ☐ None How do you like your work: ☐ Above average ☐ Average ☐ Below Average ☐ N/A My job stress is: ☐ Severe ☐ Moderate ☐ Minimal ☐ None ☐ N/A

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:

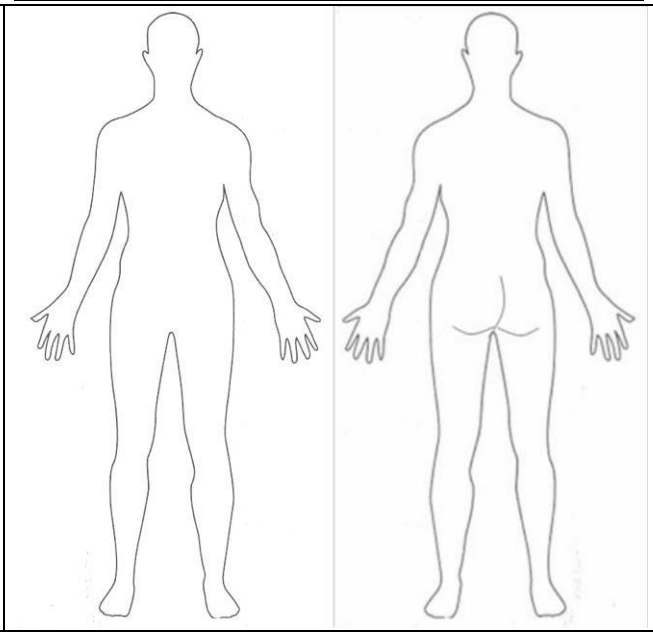
Do your maternal or paternal grandparents have any major medical problems (past or present) that are part of their history?
☐ Yes ☐ No

If yes, please describe:

1. Current/Chronic Pain: What type of pain are you/have you been experiencing?
   ☐ 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:

_____

_____

_____

_____

_____