

HEALTH QUESTIONNAIRE

Personal Information

Full name _____ Name you wish to be called _____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail: _____

Date of birth ____/____/____ Gender: M / F Insurance Company: _____

Occupation: _____ Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

Primary Concern

What brings you to my office? _____

Date of original condition: _____ Date of most recent occurrence: _____

Was there an event that created the condition? _____

Have you had this or similar conditions in the past? _____

What makes it better ? _____ Worse? _____

Is the condition getting worse? _____ Constant? _____

Worse at a certain time of day? _____

As this condition interfering with Work? _____ Sleep? _____ Activity? _____

Other? _____

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well being.

Health History

List other current health issues & problems: _____

List other practitioners seen, treatments, self-care activities, and results: _____

List illness you have had not previously mentioned, if any:

List all surgeries you have had, with dates and results: _____

Have you ever been in an accident or seriously injured? (if so, please describe) _____

Do you have any dental or TMJ problems?

Have you had your wisdom teeth removed? Yes No Have you had other teeth removed? No Yes (which one(s)?) _____

List all medications, vitamins, herbs and other supplements you are now taking: _____

List all medications and other substances (i.e.: foods) to which you are allergic:

Pain Questionnaire

(Skip to the next section if you are not currently experiencing pain.)

**Please place a single vertical line through the scale below at the point that best describes your pain.
(0 is no pain, 10 is the worst pain imaginable)**

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache

B = Burning

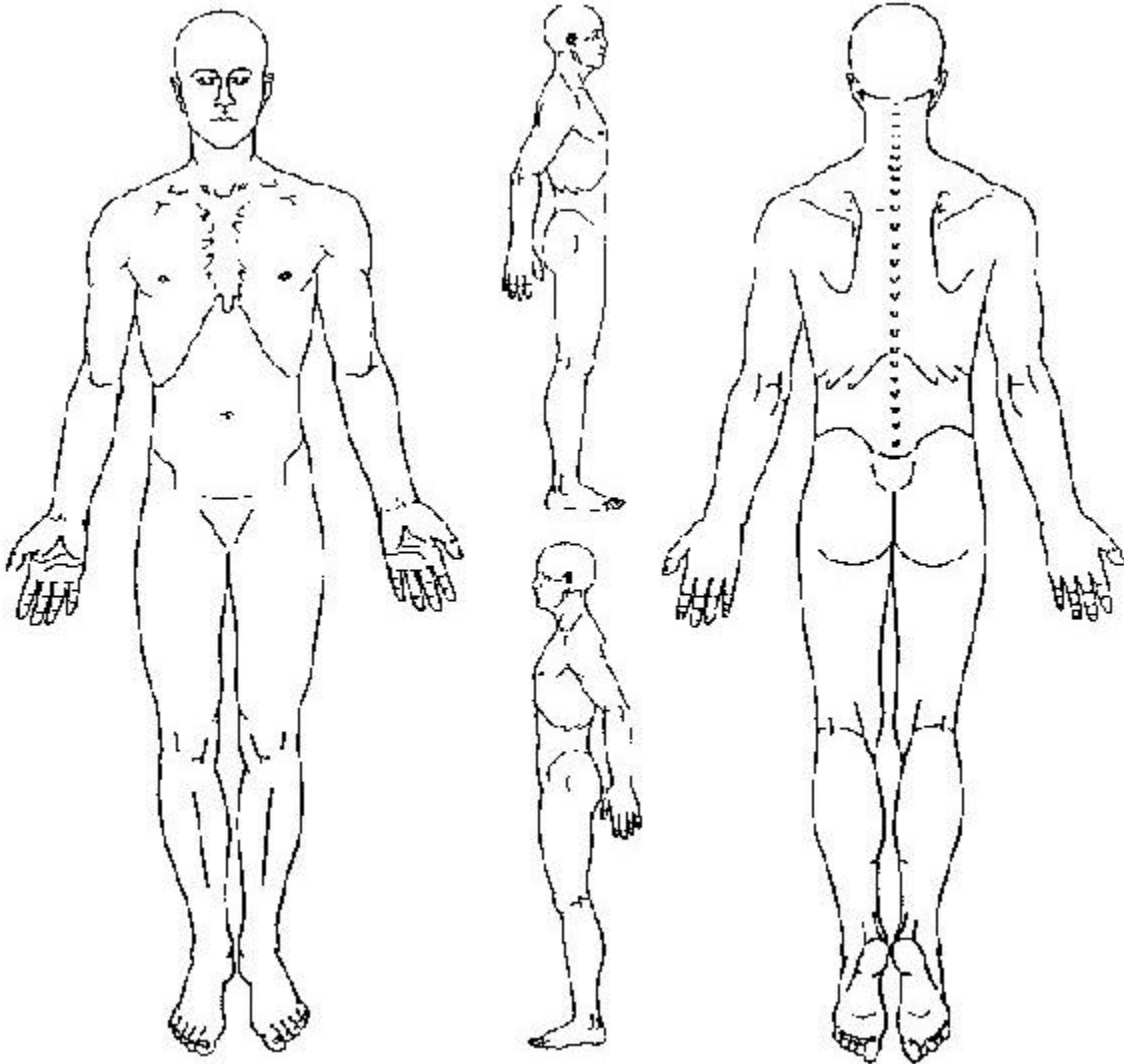
N = Numbness

O = Other

P = Pins & Needles

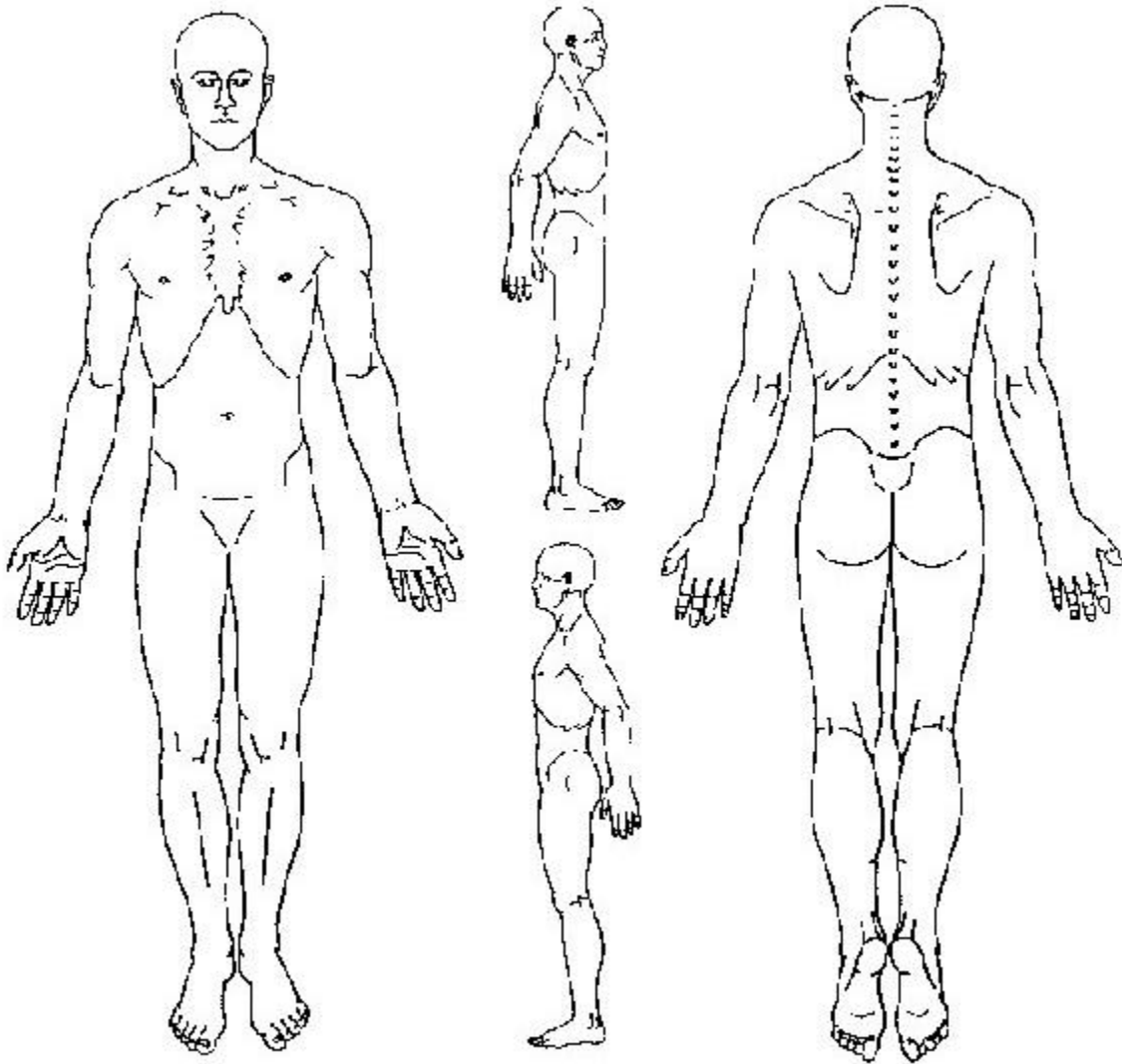
S = Stabbing

T = Throbbing



History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.).



SYMPTOM SURVEY

Circle the symptom if you are currently experiencing it or it is a common occurrence. Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

GENERAL

- Low energy -fatigue
- Weakness
- Fever - Chills
- Headaches
- Lack of sleep
- Reduced mental acuity

SKIN

- Dry skin
- Itching
- Varicose veins
- Cold or canker sores/fever blisters
- Boils
- Hives
- Rashes
- Sores
- Change in your skin/nails

EYES

- Cataracts/Glaucoma
- Eye pain
- Double vision
- Far or near sightedness
- Flashing lights
- Spots, specks, or floaters

EARS

- Ear discharge/excessive wax
- Earaches or infections
- Hearing loss
- Ringing/tinnitus
- Vertigo/dizziness

NOSE/SINUS

- Sinus congestion
- Frequent colds/infections
- Nosebleeds

NECK

- Goiter
- Lumps
- Pain/stiffness
- Swollen glands

RESPIRATORY

- Asthma
- Bronchitis
- Cough
- Pneumonia
- Tend to hold breath
- Wheezing
- Sputum
- Trouble breathing w/exercise

CARDIAC / VASCULAR

- Arrhythmia
- Chest pain
- Heart trouble
- Murmur
- High blood pressure
- Palpitations
- Shortness of breath
- Swollen feet or lower legs
- Racing or pounding heart
- Blood clots
- Leg cramps
- Poor circulation

MOUTH/THROAT

- Bleeding gums
- Dentures
- Tooth decay
- Frequent sore throats
- Grind teeth at night
- Hoarse voice/frequent loss of voice

NEUROLOGIC

- Blackouts
- Fainting
- Numbness
- Paralysis
- Dizziness
- Tremors
- Seizures

HEMATOLOGIC

- Anemia
- Bruise easily

ENDOCRINE

- Diabetes
- Excessive thirst or hunger
- Excessive sweating
- Lack of sweating
- Heat or cold intolerance
- Thyroid problem
- Hair loss
- Dizzy when standing/rising quickly
- Excessive weight loss
- Excessive weight gain

URINARY

- Frequent urination
- Blood in urine
- Incontinence
- Painful urination
- Urinate more than once at night

GASTROINTESTINAL

- Belching
- Flatulence/gas
- Black or tarry stools
- Blood in stool
- Change in stool
- Colitis
- Constipation
- Diarrhea
- Distention
- Excessive hunger
- Heartburn
- Food intolerance
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Stomach pain
- Trouble swallowing
- Vomiting

PSYCHOLOGICAL

- Anxiety
- Depression
- Insomnia / hard to fall asleep
- Nervousness
- Poor memory / forget quickly
- Violent thoughts
- Suicidal ideas
- Tend to worry

MUSCLES & JOINTS

- Arthritis
- Tendonitis
- Bursitis
- Gout
- Trouble with/poor posture
- Chronic pain
- Pain with specific movement(s)
- Pain relieved with anti-inflammatory drugs (aspirin, ibuprofen, Vioxx, etc...)
- Pain, tenderness, or numbness in:
 - Neck
 - Shoulders
 - Arms
 - Elbows
 - Wrist/hands
 - Upper back
 - Lower back
 - Hips
 - Knees
 - Feet/ankles

FEMALE

- Bleeding between periods
- Decrease sexual interest
- Pain with intercourse
- Discharge
- Itching
- Sores
- Yeast infections
- Sexually Transmitted disease
- PMS
 - Breast tenderness
 - Cramping/bloating
 - Back Pain
 - Over-emotional
 - Tired/fatigue
 - Other pain
 - Other symptoms
- Age at first period _____
- Number of days in cycle _____
- Usual length of period _____
- Start of last menstrual period date _____
- Number of pregnancies _____
- Number of deliveries _____
- Complications with pregnancies _____
- Birth control method _____

MALE

- Prostate problems
- Loss of sexual interest
- Hernia
- Erection trouble
- Discharge
- Premature ejaculation
- Sexually transmitted disease
- Testicular lump/pain
- Itching/rashes

