CHIROPRACTIC HEALTH QUESTIONNAIRE

Southern States Chiropractic

Patient Name _____ Date: _____

Reason for visit _____

Have you been treated before this problem? ❑No ❑Yes If so, by whom? _____

Type of speciality? ❑Doctor of Chiropractic ❑Physical Therapist ❑Medical Doctor ❑Other _____

What did they do and/or recommend? _____

Any diagnostic testing obtained? ❑MRI ❑CT Scan ❑X-Ray ❑Other _____

Surgical History: _____

Cancer History: ❑No ❑Yes If yes, type? _____ Date of Diagonsis: _____ Date of Remission: _____

Who is your family doctor? _____ Date of last physical exam: _____

PAST/CURRENT MEDICAL CONDITIONS Check (✓) all that apply.

❑ AIDS	❑ Diabetes	❑ Liver disease	❑ Rheumatic fever
❑ Alcoholism	❑ Emphysema	❑ Measles	❑ Scarlet fever
❑ Anemia	❑ Epilepsy	❑ Migraine headaches	❑ Stroke
❑ Anorexia	❑ Fractures	❑ Miscarriage	❑ Suicide attempt
❑ Appendicitis	❑ Glaucoma	❑ Mononucleosis	❑ Thyroid problems
❑ Arthritis	❑ Goiter	❑ Multiple sclerosis	❑ Tonsillitis
❑ Asthma	❑ Gonorrhea	❑ Mumps	❑ Tuberculosis
❑ Bleeding disorders	❑ Gout	❑ Osteoporosis	❑ Tumors, growths
❑ Breast lump	❑ Heart disease	❑ Pacemaker	❑ Typhoid fever
❑ Bronchitis	❑ Hepatitis	❑ Pneumonia	❑ Ulcers
❑ Bulimia	❑ Hernia	❑ Polio	❑ Vaginal infections
❑ Cancer	❑ Herpes	❑ Prostate problem	❑ Veneral disease
❑ Cataracts	❑ High cholesterol	❑ Prosthesis	❑ Whooping cough
❑ Chemical dependency	❑ HIV positive	❑ Psychiatric care	❑ Other _____
❑ Chicken pox	❑ Kidney disease	❑ Rheumatoid arthritis	❑ _____

MEDICATIONS List medications you are currently taking.	VITAMINS/HERBAL/MINERALS
Allergies	

GENERAL SYMPTOMS Check (✓) conditions you currently have or have had in the past year.

GENERAL
- ❑ Bruise easily
- ❑ Chills
- ❑ Dental problems
- ❑ Depression
- ❑ Difficulty sleeping
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

GASTROINTESTINAL
- ❑ Appetite poor
- ❑ Nausea
- ❑ Rectal Bleeding
- ❑ Stomach pain
- ❑ Bowel changes

SKIN
- ❑ Changes in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressue
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

EYE/EAR/NOSE
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hoarsness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision -flashes
- ❑ Vision - halos

WOMEN ONLY
- ❑ Abnormal pap smear
- ❑ Extreme menstrual pain
- ❑ Hot flashes

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Pregnant? ❑Yes ❑No ❑Unknown
Number of children _____

NECK, BACK, EXTREMITIES (Check (✓) conditions you currently have.

NECK
- ❑ Pain in neck
- ❑ Neck stiffness
- ❑ Neck weakness
- ❑ Pinched nerve in neck
- ❑ Neck feels out of place
- ❑ Muscles spasms in neck
- ❑ Grinding/popping sounds in neck

SHOULDERS	**Right**	**Left**
❑ Pain in shoulders joint	❑R	❑L
❑ Pain across shoulders	❑R	❑L
❑ Can't raise arm		
❑ Above shoulder level		
❑ Over head		
❑ Tension in shoulders	❑R	❑L
❑ Pinched nerve in shoulders		

MID-BACK
- ❑ Mid-back pain
- ❑ Mid-back stiffness
- ❑ Pain between shoulder blades
- ❑ Pain from front to back
- ❑ Muscle spasms in mid-back

ARMS & HANDS	**Right**	**Left**
❑ Pain in upper arm	❑R	❑L
❑ Pain in elbow	❑R	❑L
❑ Pain in forearm	❑R	❑L
❑ Pain in hand	❑R	❑L
❑ Pain in fingers	❑R	❑L
❑ Pins & needles in arms	❑R	❑L
❑ Pins & needles in fingers	❑R	❑L
❑ Numbness in arm	❑R	❑L
❑ Numbness in fingers	❑R	❑L
❑ Weakness of arm	❑R	❑L
❑ Weakness of hand	❑R	❑L
❑ Hands cold	❑R	❑L

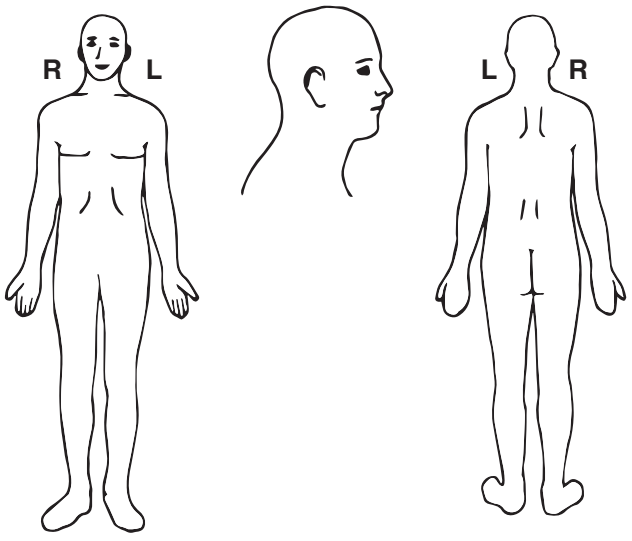
LOW BACK
- ❑ Low back pain
- ❑ Burning in low back
- ❑ Low back stiffness
- ❑ Pinched nerve in low back
- ❑ Low back feels out of place
- ❑ Muscle spasms in low back

HIPS, LEGS & FEET	**Right**	**Left**
❑ Pain in buttocks	❑R	❑L
❑ Pain in hip joint	❑R	❑L
❑ Pain in down leg	❑R	❑L
❑ Pain in knee	❑R	❑L
❑ Pain in ankle	❑R	❑L
❑ Pain in foot	❑R	❑L
❑ Weakness of leg	❑R	❑L
❑ Weakness of knee	❑R	❑L
❑ Leg cramps	❑R	❑L

OTHER SYMPTOMS:

_____
_____
_____
_____
_____
_____
_____
_____

Please mark your areas of pain on the figures below.



I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date

Reviewed by _____ _____
Doctor Date