Heritage Chiropractic Health Center, Inc

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HEALTH QUESTIONNAIRE

PERSONAL DATA

Name:____________________ Age:______ Ht:______ Wt:______

Referred by?________________ Family Physician?________________

CHIEF COMPLAINT: (What is the reason for your visit?)________________

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HISTORY OF PRESENT PROBLEM: When did your symptoms begin?________________

☐ Work Injury ☐ Auto Accident ☐ Spontaneous Onset ☐ Other________________

Briefly describe:________________________________

____

Ever had such symptoms in the past? ☐ Yes ☐ No Explain:________________

Past treatments: ☐ Physical Therapy ☐ Chiropractic ☐ Nerve block ☐ Epidural injection ☐ Biofeedback
☐ Surgery ☐ Other:________________ Briefly describe response:________________

Past tests: ☐ Labs ☐ X-rays ☐ MRI ☐ EMG ☐ Other:________________

Since the onset of your problem, have your symptoms changed? ☐ Yes ☐ No If so, how?________________

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Are your symptoms: ☐ Constant ☐ Sharp ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Intermittent ☐ Dull
☐ Shooting ☐ Aching ☐ Other________________

Do you experience: ☐ Numbness ☐ Tingling ☐ Weakness ☐ Other:________________

What increases your pain?: ☐ Walking ☐ Lifting ☐ Lying ☐ Twisting ☐ Sitting ☐ Bending ☐ Standing
☐ Reaching ☐ Other:________________

What decreases your pain? ☐ Heat ☐ Rest ☐ Reclining ☐ Sitting ☐ Walking ☐ Ice ☐ Activity ☐ Standing
☐ Other:________________

Does pain interfere with? ☐ Work ☐ Daily Activities ☐ Social Life ☐ Hobbies ☐ Relationships

Where would you rate your pain? (mark an "x" on the line)

No pain ________________________________ Worst Imaginable Pain

Medical History

Current Medications	Dosage	Times per Day	Condition Being Treated

PHARMACY NAME, CITY AND PHONE NUMBER ________________

VITAMINS/SUPPLEMENTS________________

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ALLERGIES? (Medication, food/other)________________