

# HEALTH QUESTIONNAIRE

Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

## PATIENT INFORMATION

FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_  
NAME YOU WOULD LIKE TO BE CALLED, IF DIFFERENT: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  M  F  
ADDRESS: \_\_\_\_\_ APT #: \_\_\_\_\_ HOME PH: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CELL PH: \_\_\_\_\_  
MARITAL STATUS:  SINGLE  MARRIED  WIDOWED  DIVORCED  OTHER \_\_\_\_\_ # of Children: \_\_\_\_\_  
SPOUSE / PARTNER'S NAME: \_\_\_\_\_ EMERGENCY CONTACT #: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

It is imperative that we have a current email address for all of our patients. This is how we do most of our Office/Patient communication.

I WILL BE PAYING TODAY BY:  CASH  CHECK  VISA  MASTERCARD  AMEX  DISCOVER  OTHER

## REFERRAL SOURCE: The majority of our practice members come from referrals.

WERE YOU REFERRED BY A PATIENT OF OURS?  YES  NO PATIENT NAME: \_\_\_\_\_  
WERE YOU REFERRED BY YOUR MEDICAL DOCTOR?  YES  NO NAME: \_\_\_\_\_  
IF YOU WERE NOT REFERRED, HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

## EMPLOYMENT

EMPLOYER'S NAME: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYMENT STATUS:  FULL TIME  PART TIME  RETIRED  UNEMPLOYED

## CLAIM / INSURANCE INFORMATION

IS YOUR CONDITION DUE TO:  AN AUTO ACCIDENT  A PERSONAL INJURY  A WORK INJURY  OTHER  
IF DUE TO AN INJURY, WHAT WAS THE DATE OF THE INJURY? \_\_\_\_\_  
DID YOU LOSE ANY DAYS FROM WORK? IF SO, WHICH DATES? \_\_\_\_\_  
RELATIONSHIP TO INSURED?  SELF  SPOUSE  CHILD  OTHER INSURED'S DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
INSURED'S EMPLOYER:  SAME AS ABOVE  OTHER: \_\_\_\_\_  
INSURED'S SSN:  SAME AS ABOVE  \_\_\_\_ - \_\_\_\_ - \_\_\_\_ INSURED'S DOB:  SAME AS ABOVE  \_\_\_\_/\_\_\_\_/\_\_\_\_  
**PRIMARY INSURANCE CO.** \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
**SECONDARY INSURANCE CO.** \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

## PERSONAL HEALTH HISTORY

HAVE YOU EVER HAD YOUR SPINE OR NERVOUS SYSTEM EXAMINED PROFESSIONALLY?  YES  NO  
HAVE YOU EVER RECEIVED ANY FORM OF CHIROPRACTIC CARE?  YES  NO  
IF YES, WHO WAS YOUR CHIROPRACTOR? \_\_\_\_\_ HOW LONG DID YOU RECEIVE CARE? \_\_\_\_\_  
HOW OFTEN DID YOU GO? \_\_\_\_\_ WHEN WAS YOUR LAST VISIT? \_\_\_\_\_  
WERE YOU PLEASED WITH HIS OR HER SERVICE?  YES  NO  SOMEWHAT  
HAVE YOU SERVED IN THE MILITARY?  YES  NO DATE: \_\_\_\_\_ to \_\_\_\_\_ WERE YOU IN COMBAT?  YES  NO  
DURING THE DAY, I:  SIT  STAND  WALK  DRIVE  DO DESK WORK  PHONE WORK  MECHANICAL WORK  HEAVY LIFTING  
I EXERCISE:  DAILY  WEEKLY  MONTHLY DETAILS: \_\_\_\_\_

# WHAT BROUGHT YOU TO OUR OFFICE TODAY?

<p><b>LOCATION OF PRIMARY COMPLAINT</b></p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Front of the Head</p> <p><input type="checkbox"/> Top and/or Sides</p> <p><input type="checkbox"/> Back of the Head</p> <p><input type="checkbox"/> Jaw</p> <p><input type="checkbox"/> Eye</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Upper Back</p> <p><input type="checkbox"/> Mid Back</p> <p><input type="checkbox"/> Lower Back</p> <p><input type="checkbox"/> Chest</p> <p><input type="checkbox"/> Abdomen</p> <p><input type="checkbox"/> Ribs</p> <p><input type="checkbox"/> Buttocks</p> <p><input type="checkbox"/> Shoulder</p> <p><input type="checkbox"/> Upper Arm</p> <p><input type="checkbox"/> Forearm</p> <p><input type="checkbox"/> Hand</p> <p><input type="checkbox"/> Hip</p> <p><input type="checkbox"/> Leg</p> <p><input type="checkbox"/> Foot</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p>	<p><b>TYPE OF PAIN</b></p> <p><input type="checkbox"/> Dull                      <input type="checkbox"/> Sharp                      <input type="checkbox"/> Aching                      <input type="checkbox"/> Cutting</p> <p><input type="checkbox"/> Throbbing                      <input type="checkbox"/> Burning                      <input type="checkbox"/> Numbing                      <input type="checkbox"/> Tingling                      <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Spasm                      <input type="checkbox"/> Stinging                      <input type="checkbox"/> Shooting                      <input type="checkbox"/> Pounding                      <input type="checkbox"/> Constricting</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p><b>PAIN FREQUENCY - Awake Time</b>                      <b>PAIN INTENSITY - Daily Activities</b></p> <p><input type="checkbox"/> Up to 1/4 of awake time    <input type="checkbox"/> 1/4 to 1/2 of awake time                      <input type="checkbox"/> Doesn't affect    <input type="checkbox"/> Somewhat affects</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time    <input type="checkbox"/> Most all the time                      <input type="checkbox"/> Seriously affects    <input type="checkbox"/> Prevents activities</p> <hr/> <p><b>HOW LONG HAVE YOU HAD THIS CONDITION?</b> _____</p> <hr/> <p><b>PLEASE INDICATE THE ONSET OF YOUR CONDITION:</b>                      <input type="checkbox"/> IMMEDIATE    <input type="checkbox"/> GRADUAL</p> <hr/> <table style="width: 100%;"> <tr> <td style="width: 45%; vertical-align: top;"> <p><b>DOES THE PAIN RADIATE?</b></p> <p>Head    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Neck    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Shoulder    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Arm    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Hand    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Hip    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Leg    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Foot    <input type="checkbox"/> L    <input type="checkbox"/> R</p> </td> <td style="width: 55%; vertical-align: top;"> <p style="text-align: center;"><b>ACTIONS AFFECTING THIS PAIN</b></p> <p style="text-align: center;"><b>B</b> - Brings on pain    <b>A</b> - Aggravates pain    <b>R</b> - Relieves pain</p> <p>In the AM    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Sneezing    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>In the PM    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Straining    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Bending Forward    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Standing    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Bending Backward    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Sitting    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Bending Left    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Lifting    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Bending Right    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Walking    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Twisting Left    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Hot Packs    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Twisting Right    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Cold Packs    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Coughing    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Rest    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p style="text-align: right;">Medications    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> </td> </tr> </table> <hr/> <p><b>SINCE YOUR SYMPTOMS BEGAN, HAVE YOU NOTICED A CHANGE IN:</b>                      <input type="checkbox"/> Bowel Function    <input type="checkbox"/> Bladder Function    <input type="checkbox"/> Sexual Function</p> <hr/> <p><b>PRIOR SIMILAR SYMPTOMS</b></p> <p><b>My most recent prior similar symptoms occurred on</b> _____ or _____</p> <p><input type="checkbox"/> I have <b>NOT</b> had prior symptoms to my current complaints                      <input type="checkbox"/> months ago</p> <p><input type="checkbox"/> My current complaints <b>DID</b> exist before, but had been dormant                      <input type="checkbox"/> years ago</p> <p><input type="checkbox"/> My current complaints <b>ALREADY</b> existed &amp; were worsened</p>	<p><b>DOES THE PAIN RADIATE?</b></p> <p>Head    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Neck    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Shoulder    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Arm    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Hand    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Hip    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Leg    <input type="checkbox"/> L    <input type="checkbox"/> R</p> <p>Foot    <input type="checkbox"/> L    <input type="checkbox"/> R</p>	<p style="text-align: center;"><b>ACTIONS AFFECTING THIS PAIN</b></p> <p style="text-align: center;"><b>B</b> - Brings on pain    <b>A</b> - Aggravates pain    <b>R</b> - Relieves pain</p> <p>In the AM    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Sneezing    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>In the PM    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Straining    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Bending Forward    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Standing    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Bending Backward    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Sitting    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Bending Left    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Lifting    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Bending Right    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Walking    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Twisting Left    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Hot Packs    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Twisting Right    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Cold Packs    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p>Coughing    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R                      Rest    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p> <p style="text-align: right;">Medications    <input type="checkbox"/> B    <input type="checkbox"/> A    <input type="checkbox"/> R</p>
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**WHAT OTHER DOCTORS HAVE YOU SEEN FOR THIS CONDITION?**

Name: \_\_\_\_\_

Type: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Name: \_\_\_\_\_

Type: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

HOW DO YOU GRADE YOUR PHYSICAL HEALTH?     EXCELLENT     GOOD     FAIR     POOR     GETTING BETTER     GETTING WORSE

AND YOUR EMOTIONAL / MENTAL HEALTH?     EXCELLENT     GOOD     FAIR     POOR     GETTING BETTER     GETTING WORSE

IF YOU CONSIDER YOURSELF ILL, WHY DO YOU FEEL THAT YOU ARE ILL? \_\_\_\_\_

IF YOU CONSIDER YOURSELF WELL, WHY DO YOU FEEL THAT YOU ARE WELL? \_\_\_\_\_

Please fill in the number next to each category that applies. If you are able to perform a listed function with no pain, please leave it blank.

2. I can do it without much difficulty, despite some pain.

3. I manage to do it myself, despite some marked pain.

4. I manage to do it, despite the pain, but only if I have help.

5. I cannot do it at all because of the pain.

### Difficulty with Self Care & Personal Hygiene

- |                    |                        |                        |
|--------------------|------------------------|------------------------|
| _____ Bathing      | _____ Brushing Teeth   | _____ Preparing Meals  |
| _____ Showering    | _____ Making Bed       | _____ Eating           |
| _____ Washing Hair | _____ Putting on Shirt | _____ Cleaning Dishes  |
| _____ Drying Hair  | _____ Putting on Shoes | _____ Taking Out Trash |
| _____ Combing Hair | _____ Tying Shoes      | _____ Doing Laundry    |
| _____ Washing Face | _____ Putting on Pants | _____ Going to Toilet  |

### Difficulty with Physical Activities

- |                 |                       |                       |                                 |
|-----------------|-----------------------|-----------------------|---------------------------------|
| _____ Standing  | _____ Kneeling        | _____ Twisting Left   | _____ Standing for Long Periods |
| _____ Sitting   | _____ Reaching        | _____ Twisting Right  | _____ Sitting for Long Periods  |
| _____ Reclining | _____ Bending Forward | _____ Leaning Forward | _____ Walking for Long Periods  |
| _____ Walking   | _____ Bending Back    | _____ Leaning Back    | _____ Kneeling for Long Periods |
| _____ Stooping  | _____ Bending Left    | _____ Leaning Left    |                                 |
| _____ Squatting | _____ Bending Right   | _____ Leaning Right   |                                 |

### Difficulties with Functional Activities

- |                              |                                 |                                     |
|------------------------------|---------------------------------|-------------------------------------|
| _____ Carrying Small Objects | _____ Lifting weights off Floor | _____ Pushing things while Seated   |
| _____ Carrying Large Objects | _____ Lifting weights off Table | _____ Pushing things while Standing |
| _____ Carrying a Briefcase   | _____ Climbing Stairs           | _____ Pulling things while Seated   |
| _____ Carrying a Large Purse | _____ Climbing Inclines         | _____ Pulling things while Standing |
| _____ Exercising Upper Body  | _____ Exercising Arms           |                                     |
| _____ Exercising Lower Body  | _____ Exercising Legs           |                                     |

### Difficulties with Social & Recreational Activities

- |               |                |                          |                  |
|---------------|----------------|--------------------------|------------------|
| _____ Bowling | _____ Dancing  | _____ Ice Skating        | _____ Hobbies    |
| _____ Golfing | _____ Swimming | _____ Roller Skating     | _____ Dating     |
| _____ Jogging | _____ Skiing   | _____ Competitive Sports | _____ Dining Out |

### Difficulty with Traveling

- |                                |  |
|--------------------------------|--|
| _____ Driving a Motor Vehicle  | _____ Riding as a Passenger in a Motor Vehicle |
| _____ Driving for Long Periods | _____ Riding as a Passenger on an Airplane     |
|                                | _____ Riding as a Passenger on a Train         |
|                                | _____ Riding as a Passenger for Long Periods   |

### Difficulty with Different Forms of Communication, the Senses, Hand Functions, Sleep & Sexual Function

- |  |                 |                |  |                              |
|--|-----------------|----------------|--|------------------------------|
| _____ Concentrating                                    | _____ Hearing   | _____ Touch    | _____ Taste  | _____ Smell                  |
| _____ Keyboarding                                      | _____ Listening | _____ Speaking | _____ Reading  | _____ Writing                |
| _____ Grasping   | _____ Holding   | _____ Pinching | _____ Percussive Movements                                 | _____ Sensory Discrimination |
| _____ Being able to have a normal, restful night sleep |                 |                | _____ Being able to participate in desired sexual activity |                              |

The AMA has found that more than 80% of all health problems are due to stress. Stress affects the nervous system. When the nervous system is affected by stress, this can cause Vertebral Subluxations.

The practice of chiropractic is based upon the location and adjustment of Vertebral Subluxation. Spinal Subluxations are caused by any stress your body can not properly perceive, adapt to or recover from.

These stresses may be PHYSICAL, CHEMICAL or EMOTIONAL / MENTAL in nature. Often the first subluxation can be experienced at birth.

**PHYSICAL STRESS:** Please check "**P**" for Past, "**C**" for Current (or both if they apply)

FALLS FROM CRIB / BED	<input type="checkbox"/> P	<input type="checkbox"/> C	FALLS DOWN / UP STEPS	<input type="checkbox"/> P	<input type="checkbox"/> C	FALLS ON ICE	<input type="checkbox"/> P	<input type="checkbox"/> C
SPORTS IMPACTS	<input type="checkbox"/> P	<input type="checkbox"/> C	PHYSICAL FIGHTS	<input type="checkbox"/> P	<input type="checkbox"/> C	ARMED SERVICES	<input type="checkbox"/> P	<input type="checkbox"/> C
HAVE YOU BEEN KNOCKED UNCONSCIOUS?			<input type="checkbox"/> YES			<input type="checkbox"/> NO		
HAVE YOU EVER USED CRUTCHES, A WALKER OR A CANE?			<input type="checkbox"/> YES			<input type="checkbox"/> NO		
HAVE YOU EVER BROKEN ANY BONES?			<input type="checkbox"/> YES			<input type="checkbox"/> NO		
HAVE YOU EVER HAD ANY IMPACTS, FALLS OR JOLTS THAT YOU FEEL SPECIFICALLY MAY HAVE INJURED YOUR SPINE?							<input type="checkbox"/> YES	<input type="checkbox"/> NO
HAVE YOU EVER HAD ANY EXTENSIVE DENTAL OR ORTHODONTIAL WORK DONE?							<input type="checkbox"/> YES	<input type="checkbox"/> NO

**CHEMICAL STRESS:**

ARE YOU NOW TAKING ANY DRUG (PRESCRIPTION, OVER-THE-COUNTER OR RECREATIONAL) REGULARLY?

DRUG: _____	DATE PRESCRIBED: _____	REASON: _____
DRUG: _____	DATE PRESCRIBED: _____	REASON: _____
DRUG: _____	DATE PRESCRIBED: _____	REASON: _____
DRUG: _____	DATE PRESCRIBED: _____	REASON: _____
DRUG: _____	DATE PRESCRIBED: _____	REASON: _____

ARE THESE DRUGS BEING PRESCRIBED BY A PHYSICIAN?  YES  NO

DO YOU OR DID YOU WORK WITH ANY CHEMICAL, FUME, DUST, POWDER OR SMOKE FOR PROLONGED PERIODS?  YES  NO

PLEASE EXPLAIN: \_\_\_\_\_

DO YOU CONSUME: (**O** - DO NOT CONSUME, **D** - CONSUME DAILY, **W** - CONSUME WEEKLY, **M** - CONSUME MONTHLY)

	O	D	W	M		O	D	W	M		O	D	W	M
ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EGGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BEEF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COFFEE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CANNED VEGETABLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POULTRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RAW VEGETABLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FISH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL SWEETENERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FRESH FRUIT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SEAFOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SODA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WHOLE GRAINS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WEIGHT CONTROL PILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIET FOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DAIRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ORGANIC FOODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFINED SUGAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FRIED FOODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU FAST?	<input type="checkbox"/> YES			<input type="checkbox"/> NO

**EMOTIONAL / MENTAL STRESS:** FOR EACH OF THE FOLLOWING POTENTIAL SPINAL STRESS SITUATIONS, PLEASE CHECK "**P**" for Past, "**C**" for Current (or both if they apply) UNDER THE LEVEL OF TRAUMA SEVERITY.

	MILD			MODERATE			EXTREME		
	P	C		P	C		P	C	
CHILDHOOD STRESS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
SCHOOL STRESS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
PLAY OR RECREATIONAL	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
FAMILY STRESS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
PERSONAL RELATIONSHIPS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
STRESS OF BEING SICK	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
WORK RELATED STRESS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
STRESS OF COMMUTING	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
LOSS OF A LOVED ONE	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
CHANGE IN LIFESTYLE	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
CHANGE IN VOCATION	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
ABUSE	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

**AUTOMOBILE ACCIDENTS:** HAVE YOU (EVEN AS A PASSENGER AND EVEN IF YOU DO NOT THINK YOU WERE HURT) BEEN INVOLVED IN A VEHICULAR COLLISION OR NEAR COLLISION? PLEASE LIST APPROXIMATE DATES AND SEVERITY (MILD, MODERATE, SEVERE OR EXTREME).

AUTOMOBILE: \_\_\_\_\_

BUS, BICYCLE, MOTORCYCLE, TRAIN, AIRPLANE, MO-PED OR OTHER VEHICLES: \_\_\_\_\_

## SPORTS & LEISURE

IN THE PAST, WERE YOU ACTIVE IN SPORTS?  YES  NO WHICH ONE(S)? \_\_\_\_\_

ARE YOU CURRENTLY ACTIVE IN SPORTS?  YES  NO WHICH ONE(S)? \_\_\_\_\_

HAVE YOU BEEN HURT IN ANY OF THESE ACTIVITIES?  YES  NO WHEN? \_\_\_\_\_

DO YOU READ FOR PROLONGED PERIODS?  YES  NO DO YOU PLAY A MUSICAL INSTRUMENT?  YES  NO

DO YOU HAVE A PARTICULAR POSITION FOR WATCHING TV OR READING?  YES  NO DETAILS: \_\_\_\_\_

DO YOU WEAR:  GLASSES  BIFOCALS  TRIFOCALS  CONTACT LENSES  N/A  OTHER \_\_\_\_\_

## MEDICAL TREATMENT

HAVE YOU EVER BEEN HOSPITALIZED?  YES  NO WHEN? \_\_\_\_\_

IF YES, WHY? \_\_\_\_\_ WHAT WAS ACTUALLY DONE TO YOU? \_\_\_\_\_

HAVE YOU HAD SURGERY?  YES  NO IF YES, PLEASE EXPLAIN: \_\_\_\_\_

DO YOU STILL HAVE ALL YOUR BODY PARTS?  YES  NO IF NO, PLEASE EXPLAIN: \_\_\_\_\_

HAVE YOU HAD:  A SPINAL TAP  PHYSIOTHERAPY  NECK COLLAR  SPINAL BRACE  TRACTION  HEEL LIFT  
 SPINAL INJECTIONS  RADIATION TREATMENTS  CORRECTIVE SHOES OR BARS ON SHOES  EXTENSIVE DIAGNOSTIC X-RAYS

## AUTHORIZATIONS:

**A.** I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case and by any insurance company contractually obliged to make payment to me or you based upon the charges submitted for products and services rendered.

**B.** I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

**C.** I authorize the doctors and staff of this clinic to examine and treat me as they find necessary. I further authorize clinic personnel to release medical information regarding my care to insurance companies or other professionals if necessary. I certify that all the information I have given is true and correct. I also certify that I am here for the sole purpose of getting better and no other reason.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## COMPREHENSIVE REVIEW OF SYSTEMS

The PURPOSE of this questionnaire is to comprehensively evaluate each of your body's organ systems over the last SIX MONTHS.

**If the answer is 'Yes' then select 'A'**

If the symptom or event is persistent, then select 'A'

If the symptom or event is Frequent or common, then select 'F'

If the symptom or event is Rare or uncommon, then select 'R'

If the symptom or event has not occurred within the last 6 months, mark 'N'

N R F A	Consume breads / pastas / starches	N R F A	Can't gain weight	N R F A	Belching
N R F A	Yeast / Fungal problems	N R F A	Slow metabolism	N R F A	Ulcers
N R F A	Tickle in your throat	N R F A	Overweight	N R F A	Pain after eating
N R F A	Cough / spit clear sputum / phlegm	N R F A	Gout	N R F A	Heartburn medication
N R F A	Unexplained weight loss	N R F A	Diabetes	N R F A	Indigestion or bloating
N R F A	Nervousness or irritability	N R F A	Metabolic syndrome	N R F A	Abdominal cramps or pain
N R F A	Thinning of the skin	N R F A	Thyroid problems	N R F A	Irritable Bowel Syndrome
N R F A	Prostate problems	N R F A	Too much stress / tension	N R F A	Diarrhea
N R F A	A family history of diabetes	N R F A	Heat / cold intolerance	N R F A	Inflamed intestine - "Leaky Gut"
N R F A	A family history of cancer	N R F A	Cough/spit green-yellowish sputum	N R F A	Dark black / tarry stools
N R F A	A family history of heart disease	N R F A	Trouble with edema / swelling	N R F A	Blood on the toilet paper
N R F A	Alcohol socially	N R F A	Early aging	N R F A	Chron's Disease
N R F A	Alcohol use extensively	N R F A	Trouble sweating	N R F A	Ulcerative Colitis
N R F A	Do you use street drugs	N R F A	Fatigue or tired	N R F A	Colon polyps
N R F A	Drink coffee / soda / ice tea	N R F A	Unexplained swellings	N R F A	Diverticulitis
N R F A	Smoke or use tobacco	N R F A	Diabetic medications	N R F A	Constipation
N R F A	Eat fast food	N R F A	Thyroid medication	N R F A	Laxitives
N R F A	Eat pre processed / packaged foods	N R F A	Diuretics	N R F A	Urinary tract infections
N R F A	Consume sweets	N R F A	Erectile dysfunction	N R F A	Kidney stones
N R F A	Use artificial sweeteners	N R F A	Pre-menopause	N R F A	Blood in your urine
N R F A	Drink cow's milk	N R F A	Peri-menopause	N R F A	Bed wetting
N R F A	Consume white sugar	N R F A	Suffer from PMS	N R F A	Urinary discharge (abnormal)
N R F A	Consume refined carbs	N R F A	Breast tenderness	N R F A	Dark or smelly urine
N R F A	Consume wheat or gluten	N R F A	Vaginal discharge	N R F A	Over-active bladder
N R F A	Consume artificial flavorings	N R F A	Vaginal dryness	N R F A	Urinary urgency
N R F A	Very little exercise	N R F A	Birth control	N R F A	Urinary hesitancy
N R F A	Family or financial stressors	N R F A	Irregular periods	N R F A	Headaches or migraines
N R F A	Rashes	N R F A	Excessive period bleeding	N R F A	Stiffness or muscle spasms
N R F A	Roseacea	N R F A	Athlete's Foot	N R F A	Bone pains
N R F A	Itchy or dry skin	N R F A	Ovarian cysts	N R F A	Difficulty exercising
N R F A	Oily skin	N R F A	Fibrocystic breasts	N R F A	Fibromyalgia
N R F A	Acne	N R F A	Fertility concerns	N R F A	Chronic fatigue syndrome
N R F A	Eczema	N R F A	Increase in urination	N R F A	Back pain or neck pain
N R F A	Psoriasis	N R F A	Pelvic pain or cramping	N R F A	Joint pain
N R F A	Skin cancer	N R F A	Mood swings	N R F A	Arthritis
N R F A	Vertigo / dizziness	N R F A	Bouts of depression	N R F A	Rheumatoid arthritis
N R F A	Lightheadedness	N R F A	Manic episodes	N R F A	Muscle weakness
N R F A	Glaucoma	N R F A	Loosing your memory	N R F A	Osteoporosis
N R F A	Cataracts	N R F A	Hot flashes / sweats	N R F A	Muscle relaxors
N R F A	Double vision or blurred vision	N R F A	Thinning hair or brittle hair	N R F A	Seizures
N R F A	Dry or red eyes	N R F A	Sexually transmitted disease	N R F A	Anti-depressants
N R F A	Macular degeneration	N R F A	Decrease in sex drive	N R F A	Pain medications
N R F A	Watery eyes	N R F A	Pain with sex	N R F A	Multiple sclerosis
N R F A	Itchy eyes	N R F A	Hormone replacement	N R F A	Numbness or tingling
N R F A	Puffy eyes	N R F A	Heart medication	N R F A	Poor coordination
N R F A	Ear infections	N R F A	A heart attack	N R F A	ADD / ADHD learning disorders
N R F A	Tooth cavities	N R F A	Heart surgery	N R F A	Brain fog - lack of concentration
N R F A	Bad breath	N R F A	Chest pain / angina / tightness	N R F A	Anxiety / anxiousness
N R F A	Runny nose / sneezing	N R F A	High blood pressure	N R F A	Problems relaxing
N R F A	COPD / lung disease	N R F A	A-fib or arrhythmias	N R F A	Feelings of worthlessness
N R F A	Emphysema	N R F A	Heart problems	N R F A	Allergies
N R F A	Chronic bronchitis	N R F A	Slow or fast heart beats at rest	N R F A	Sick more often
N R F A	Difficulty breathing deeply	N R F A	Deep vein thrombosis	N R F A	Swollen glands
N R F A	Acute or chronic coughing	N R F A	Poor circulation in hands	N R F A	Recently taken antibiotics
N R F A	Wheezing with breathing	N R F A	Poor circulation in feet	N R F A	Sclerodermea or Sjogrens disease
N R F A	Asthma	N R F A	Concerns about a stroke	N R F A	Fever blisters or cold sores
N R F A	Shortness of breath	N R F A	Restless Leg Syndrome	N R F A	Warts
N R F A	Pain when taking a breath	N R F A	Bruise easily	N R F A	Sore throat
N R F A	Difficulty going to sleep	N R F A	Heart burn or reflux	N R F A	Cholesterol problems
N R F A	Hungry all the time	N R F A	Upset stomach	N R F A	Cholesterol medication
N R F A	Can't lose weight			N R F A	Gall bladder attacks