CAROLINASCHIROPRACTIC
AND SPINAL REHAB

Health Questionnaire

Patient Information

Patient Name: _____ Date of Birth:____/____/____

Medical History

Describe the reason(s) for your doctor visit today:_____

When did your symptoms start? _____ **How did your symptoms begin?** _____

Is there anything that makes your pain better?_____

Is there anything that makes your pain worse?_____

Describe your pain: (Circle one or more) Sharp Stabbing Dull Achy Stiff Tight Shooting Numb Throbbing

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Are your symptoms? (Circle one) Getting better Staying the sameGetting worse

When is the pain the worst? (Circle one) Morning Midday Night

What have you used to treat the pain? (Circle one or more) Ice Heat Rest Medication

How do your symptoms interfere with your work or normal activities?_____

Have you experienced these symptoms in the past?_____

Describe the severity of your pain: (no pain) ⓪①②③④⑤⑥⑦⑧⑨⑩ **(worst pain of life)**

History of Treatment

Primary care physician: _____ **Phone:** _____

Date last seen: _____**May we update them on your condition?** ____Yes ____ No

Have you seen a chiropractor before? ____Yes ____No **If yes, when was your last visit?** _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

_____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

_____

List any surgeries, hospitalizations, motor vehicle accidents, trauma and falls you have had, with the month and year for each: _____

_____

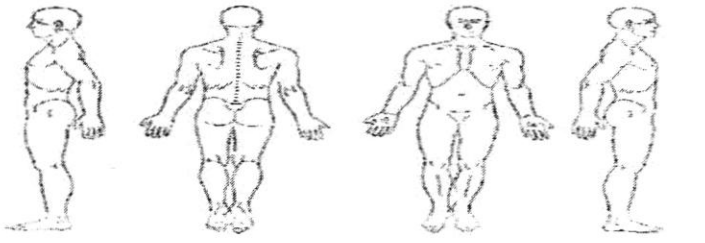
List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual): _____

Do you smoke? □ Yes □ No _____packs per day. **Are you pregnant?** □ Yes □ No

Description of Condition

Please circle the area(s) of discomfort:



Left Back Front Right

OFFICE USE ONLY: **Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____**

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
O	O	Abdominal Pain	O	O	Elbow/upper arm pain	O	O	Liver/Gall Bladder Disorder
O	O	Abnormal Weight gain/loss	O	O	Epilepsy	O	O	Loss of Bladder Control
O	O	Allergies	O	O	Excessive thirst	O	O	Low back pain
O	O	Angina	O	O	Frequent Urination	O	O	Mid back pain
O	O	Ankle/foot pain	O	O	General Fatigue	O	O	Neck pain
O	O	Arthritis	O	O	Hand pain	O	O	Painful Urination
O	O	Asthma	O	O	Headaches	O	O	Prostate Problems
O	O	Bladder Infection	O	O	Heart attack	O	O	Reflux
O	O	Blood Clots	O	O	Hepatitis	O	O	Shoulder pain
O	O	Birth Control Pills	O	O	High blood pressure	O	O	Smoking/tobacco Use
O	O	Cancer	O	O	Hip/upper leg pain	O	O	Stroke
O	O	Chest Pains	O	O	HIV/AIDS	O	O	Systematic Lupus
O	O	Chronic Sinusitis	O	O	Hormone Therapy	O	O	Thoracic Outlet Syndrome
O	O	Depression	O	O	Jaw pain	O	O	Tumor
O	O	Dermatitis/Eczema	O	O	Joint swelling/stiffness	O	O	Ulcer
O	O	Dizziness	O	O	Kidney Stones	O	O	Upper back pain
O	O	Drug/Alcohol Use	O	O	Knee/lower leg pain	O	O	Wrist pain

Patient's signature: _____ **Today's date:** _____

Doctor's signature: _____