



# Health

Please list any medications (including pain killers) you are taking: \_\_\_\_\_

Please list any serious injuries you have had in the past 10 years:

Description	Date
Falls	_____
Head Injuries	_____
Broken Bones	_____
Dislocations	_____
Surgeries	_____
Other	_____

Women: Are you pregnant?  Y  N If so, how far along? \_\_\_\_\_ Nursing?  Y  N

## Medical History Past & Present

Check (✓) yes or no whether you have had or currently have any of the following medical conditions?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attach/Stroke     | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis            | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Tendency   |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure     | <input type="checkbox"/> Y <input type="checkbox"/> N Anemia               | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures       | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis            | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease       | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gout                    | <input type="checkbox"/> Y <input type="checkbox"/> N Neck Problem         | <input type="checkbox"/> Y <input type="checkbox"/> N Leg Pain/Ankle Pain |
| <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                  | <input type="checkbox"/> Y <input type="checkbox"/> N Broken Bones         | <input type="checkbox"/> Y <input type="checkbox"/> N Hip Pain            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nervous Condition       | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain             | <input type="checkbox"/> Y <input type="checkbox"/> N Knee Pain           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies               | <input type="checkbox"/> Y <input type="checkbox"/> N Wrist Pain           | <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Pain      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Previous Foot Condition | <input type="checkbox"/> Y <input type="checkbox"/> N Shoulder Pain        | <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back Problem            | <input type="checkbox"/> Y <input type="checkbox"/> N Arm Pain/Hand Pain   |   |

Check if any of the following symptoms are present at this time.

### Eyes:

- Y  N Glasses
- Y  N Pain
- Y  N Spots
- Y  N Double Vision

### Ears:

- Y  N Pain
- Y  N Ringing/Noises
- Y  N Hearing Loss
- Y  N Loss of Balance

### Head:

- Y  N Headaches
- Y  N Trauma
- Y  N Dizziness
- Y  N Fainting

### Muscle & Joints:

- Y  N Muscle Pain
- Y  N Muscle Cramps
- Y  N Muscle Weakness
- Y  N Joint Pain
- Y  N Joint Stiffness
- Y  N Grinding/Popping
- Y  N Loss of Flexibility

### Nervous System:

- Y  N Numbness
- Y  N Tingling (pins & needles)
- Y  N Nervousness
- Y  N Coordination problems
- Y  N Convulsions

### Abdominal:

- Y  N Pain
- Y  N Gas
- Y  N Burning
- Y  N Nausea/Vomiting
- Y  N Diarrhea/Constipation

### Heart & Lungs

- Y  N Chest Pain
- Y  N Coughing
- Y  N Sputum production
- Y  N Chest Noises
- Y  N Difficulty Breathing

### Menstrual/Obstetrical

- Y  N Cramps
- Y  N Difficult Deliveries
- Y  N Breast Tenderness
- Y  N Breast Lumps

### Personal – Check best answer

- Alcohol  Heavy  Light  None
- Coffee  Heavy  Light  None
- Tobacco  Heavy  Light  None
- Drugs  Heavy  Light  None
- Exercise How often? \_\_\_\_\_
- Sleep How many Hrs.? \_\_\_\_\_
- Appetite  Good  Bad  Other

## Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the Chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the Chiropractor.

I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient or Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_