PRECISION CHIROPRACTIC

File # _____
Date: ___/___/___

# Health Questionnaire

## 1 Patient Information

**Patient Title:** (check one) ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

**First Name** _____ **Middle Name**_____ **Nick Name**_____

**Last Name** _____ **Suffix** _____ **Previous Name**_____

**Address 1** _____

**City**_____ **State**_____ **Zip Code** _____

**Primary Phone** _____ **Secondary/Mobile Phone** _____

**Home Email** _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

**Referred by:** ❑ Patient/Friend ❑ Physician ❑ Advertisement ❑ Student ❑ Community Event ❑ Sports Event ❑ Community Event ❑ Palmer's Reputation **Name of person or event:**_____

**Which email address would you like us to use to communicate with you?** (check one) ❑ Home ❑ Work
**Contact Method** (check one) ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

**Date of Birth** / / **Age** _____ **Gender** (check one) ❑ Male ❑ Female ❑ Unspecified

**Marital Status** (check one) ❑ Single ❑ Married ❑ Other **Spouse's Name**: _____

**Employment Status** (check one)

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

**What do you do for work?** _____

**What do are the most repetitive motions you do when working?**

_____

_____

**Emergency Contact Information: Full Name** _____ **Relationship:** _____

**Address:** _____ **Phone Number:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

# PRECISION CHIROPRACTIC

## 2 Patient Condition

Reason(s) for visit:_____

Is this condition due to an accident? ❑ Yes ❑ No ❑ Auto ❑ Work ❑ Home ❑ Other Date_____

What was the mechanism of accident/injury? _____

When did your symptoms appear?_____ Is it constant or does it come and go?_____

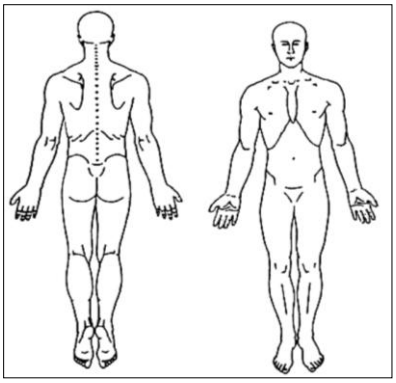
How often do you have this problem? _____ How long does the pain last?_____

Does the pain radiate? ❑ Yes ❑ No If yes, Explain: _____

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are difficult / painful to perform:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down



Mark an "X" on the picture where you continue to have pain, numbness or tingling.

Circle your pain on the below scale of 0 to 10:

(at rest) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

(with activity) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

What time of day is your current pain/problem worse?

❑ Morning ❑ Late in the day ❑ Middle of night ❑ As day progresses ❑ N/A

My current pain/problem seems to be:

❑ Getting better♦ ❑ Staying the same ❑ Getting worse♦ ❑ N/A Explain:_____

My current pain/problem can be described as (check all that apply):

❑ Electric ❑ Sharp ❑ Stabbing ❑ Knife-like ❑ Piercing ❑ Shooting ❑ Achy ❑ Griping ❑ Heavy ❑ Cramp-like

❑ Burning ❑ Deep ❑ Superficial ❑ Stiffness (am >1-2 hours or PM or Both) ❑ Spasm ❑ Tearing ❑ N/A

What treatment have you already received for your condition?

❑ Medications ❑ Surgery ❑ None ❑ Physical Therapy ❑ Chiropractic Care

Name of other doctor(s) who have treated you for this condition and how _____

_____

Were you satisfied with the results of your treatment? ❑ Yes ❑ No Explain_____

_____

## 3 Allergies

**Are you allergic to any medication(s)?**

❑ Yes ❑ No **If yes, which medications?**

_____

**Are you allergic to any of the following?**

❑ Bee Sting ❑ Latex ❑ Peanuts ❑ Shellfish

❑ Dairy ❑ Mold ❑ Pollen ❑ Wheat

❑ Eggs ❑ Nuts ❑ Other_____

**Describe the reaction:**_____

## 4 Smoking History

**Do you currently smoke tobacco of any kind?**

❑ Yes ❑ Former smoke ❑ Never been a smoker

***If yes, how often do you smoke:***

❑ Current every day smoke

❑ Current sometimes smoker

***If yes, what is your level of interest in quitting smoking?***

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest Very Interested



**Patient Initials** _____

PRECISION
CHIROPRACTIC

# 5 Medications

**Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑**

| | Medication Name | Quantity / Dosage (ie. 1 tablet / 5 mg) | Frequency (ie. 2 times / day) | Start Date |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |

Do you currently use any recreational drugs? ❑ Yes ❑ No

# 6 Social History

**WORK ACTIVITY**: What is your job description: _____

What do you do most of the day at work? ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor ❑ Other:_____

What job did you do during most of your life? _____

How would you describe the physical stress level at work? ❑ Low ❑ Medium ❑ High

**EDUCATION** : Mark the highest level of education completed: ❑ Elementary school ❑ Middle school ❑ High School ❑ Vocational School ❑ GED ❑ Associates Degree ❑ Bachelors Degree ❑ Graduate Degree ❑ Doctorate ❑ other

**DIET/NUTRITION**:

Are you on any special diet? ❑ Yes ❑ No If yes, for what reason?_____

Is your weight a concern for you emotionally or physically? ❑ Yes ❑ No

Have you gained or lost over 10 pounds in the past 6 months without wanting to? ❑ Yes ❑ No

My dietary intake consists mainly of the following: (Mark all that apply)

❑ Fruits ❑ Vegetables ❑ Whole Grains ❑ High Fiber ❑ Low Fiber
❑ High Salt ❑ Low Salt ❑ High Sugar ❑ Low Sugar ❑ Low Carbohydrate
❑ High Fat ❑ Low Saturated Fats ❑ High Protein ❑ Low Calorie

Rate your appetite on the below scale of 1 to 10:

☺Normal Appetite 1 2 3 4 5 6 7 8 9 10 Eat Nothing☹

How many 8 ounce glasses of water do you drink a day? _____

Alcohol Use: Now? ❑ Yes ❑ No Amount/Weekly____ How long? _____ Years/Months
In the past? ❑ Yes ❑ No Amount/Weekly____ How long? _____ Years/Months

How many coffee caffeine drinks do you drink a day? Cups ____ None ____

How many soda caffeine drinks do you drink a day? Cans ____ None ____

**Current Vitamins, Minerals, Herbs, etc. List ANY/ALL non-prescription items you are CURRENTLY taking.**

| | Vitamin, Mineral, Herbs | Quantity / Dosage (ie. 1 tablet / 5 mg) | Frequency (ie. 2 times / day) | Start Date |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |



**Patient Initials** _____

PRECISION
CHIROPRACTIC

**Health Review:**

How many hours of sleep are you getting per night? ❑ Less than 5 ❑ 6-8 ❑ 8-10 ❑ 10 or more hours
How would you rate your sleep on the following scale? ☺Wake-up Fully Rested 0 1 2 3 4 5 6 7 8 9 10 No/Poor Sleep☹
How many days a week do you exercise for 30 minutes or more? ❑ 0 ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7
How would you rate the intensity of your exercise? ☺High Intensity 0 1 2 3 4 5 6 7 8 9 10 No Exercise☹
How would you rate your physical stress level? ☺No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed☹
How would you rate your emotional stress level? ☺No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed☹
List your major Stressors: _____
What are you health goals? _____

**In addition**, talk to your doctor about other areas which may be affecting your health-such as worries about finances, social support, and alcohol, tobacco and/or drug use.

# 7 Personal Health History

Are your currently under the care of a Healthcare Provider or any other doctor? ❑ Yes ❑ No
If yes, for what condition(s)_____
_____
Provider's Name _____
Has any doctor diagnosed you with Hypertension recently? ❑ Yes ❑ No
If yes, describe: _____
Has any doctor diagnosed you with Diabetes recently? ❑ Yes ❑ No
If yes, was your blood lab-work test for hemoglobin A1c >9.0% ❑ Yes ❑ No ❑ Not Sure
If yes, other comments regarding Diabetes: _____
Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Do you wear any of the following? ❑ Heel Lifts ❑ Innersoles ❑ Arch Supports ❑ Orthotics ❑ Other_____
For how long? _____ Were they prescribed by a doctor? ❑ Yes ❑ No
Have you seen a chiropractor in the past? ❑ Yes ❑ No Date of last visit_____
If yes, name and location of previous Chiropractor_____ Phone Number_____
Were you satisfied with your care? ❑ Yes ❑ No Why? _____

**Childhood Illnesses:**

| | | |
|---|---|---|
| ❑ ADD | ❑ depression | ❑ Psoriasis |
| ❑ atopic dermatitis | ❑ diabetes | ❑ Rash |
| ❑ allergies/hayfever | ❑ ear infections | ❑ scoliosis |
| ❑ anemia | ❑ fetal drug exposure | ❑ seizures |
| ❑ asthma | ❑ headaches | ❑ sickle cell |
| ❑ bedwetting | ❑ hepatitis | ❑ spina bifida |
| ❑ cerebral palsy | ❑ HIV | ❑ other: |
| ❑ chicken pox | ❑ measles | |
| ❑ crohn's/colitis | ❑ mumps | |



**Patient Initials** _____

# PRECISION CHIROPRACTIC

**Adult Illnesses:**

| | | | | |
|---|---|---|---|---|
| ❑ ADD | ❑CVA(stroke) | ❑ heart disease | ❑ Parkinson Disease | ❑ suicide attempt(s) |
| ❑ Alzheimer's | ❑ chicken pox | ❑ hepatitis | ❑ Unspecified pleural effusion | ❑ thyroid problems |
| ❑ arthritis | ❑ cystic kidney disease | ❑ HIV | ❑ pneumonia | ❑ vertigo |
| ❑ asthma | ❑ depression | ❑ high blood pressure | ❑ psoriasis | ❑ Other:_____ |
| ❑ cancer | ❑ diabetes | ❑ influenza pneumonia | ❑ psychiatric condition | _____ |
| ❑ cerebral palsy | ❑ eczema | ❑ liver disease | ❑ scoliosis | |
| ❑ chicken pox | ❑ emphysema | ❑ lung disease | ❑ seizures | |
| ❑ colitis | ❑ eye problems | ❑ lupus erythema | ❑ shingles | |
| ❑ CRPS(RSD) | ❑ fibromyalgia | ❑ multiple sclerosis | ❑ STD's (unspecified) | |

**Injuries:** (List date next to injury)

| | | |
|---|---|---|
| ❑ back injury | ❑ fracture | ❑ laceration (severe) |
| ❑ broken bones | ❑ head injury | ❑ motor vehicle accident |
| ❑ disability (ies) | ❑ industrial accident | ❑ soft tissue injury |
| ❑ fall (severe) | ❑ joint injury | ❑ Other:_____ |

**Surgeries:**

| | **Date** | **Procedure** (ie knee repair) | **Description** | |
|---|---|---|---|---|
| **1** | | | | In Patient/Out Patient |
| **2** | | | | In Patient/Out Patient |
| **3** | | | | In Patient/Out Patient |
| **4** | | | | In Patient/Out Patient |
| **5** | | | | In Patient/Out Patient |

# Review of systems

Please indicate if you have any of the following by checking the box.

| | | | | |
|---|---|---|---|---|
| Constitutional | ❑ None | ❑ daytime drowsiness | ❑ fever | ❑ night sweats |
| | ❑ chills | ❑ fatigue | ❑ loss of appetite | ❑ weight gain / loss |
| Eyes/Vision | ❑ None | ❑ cataracts | ❑ itching | ❑ wears contacts/glasses |
| | ❑ blindness | ❑ double vision | ❑ photophobia | |
| | ❑ blind spots | ❑ eye problems | ❑ tearing | |
| Ears, Nose & Throat | ❑ None | ❑ fainting | ❑ history of head injury | ❑ runny nose |
| | ❑ dizziness | ❑ frequent sore throats | ❑ loss of sense of smell | ❑ sinus infection |
| | ❑ ear discharge | ❑ headaches | ❑ nosebleeds | |
| | ❑ ear pain | ❑ hearing loss | ❑ nasal congestion | |
| Respiration | ❑ None | ❑ cough | ❑ shortness of breath | ❑ wheezing |
| | ❑ asthma | ❑ coughing up blood | ❑ sputum production | |
| Cardiovascular | ❑ None | ❑ high blood pressure | ❑ paroxysmal nocturnal dyspnea | ❑ varicose veins |
| | ❑ claudication (leg pain and ache) | ❑ low blood pressure | ❑ shortness of breath with exertion | |
| | ❑ heart problem | ❑ orthopnea (difficulty breathing lying down) | ❑ ulcers | |
| | ❑ heart murmur | ❑ palpitations | | |
| Gastrointestinal | ❑ None | ❑ belching | ❑ difficulty swallowing | ❑ jaundice |
| | ❑ abdominal pain | ❑ black/tarry stool | ❑ heartburn | ❑ ulcers |
| | ❑ abnormal stool (Color/consistency) | ❑ constipation | ❑ hemorrhoids | ❑ rectal bleeding |
| | | ❑ diarrhea | ❑ indigestion | ❑ loss of bowel control |
| Female | ❑ None/N/A | ❑ birth control | ❑ frequent urination | ❑ vaginal discharge |
| | ❑ abnormal vaginal Bleeding | ❑ breast lump/pain | ❑ hormone therapy | ❑ urine retention/incontinence |
| | | ❑ burning urination | ❑ irregular menstruation | ❑ cramps |



**Patient Initials** _____

| | |
|---|---|
| | I … ❑ am currently pregnant ❑ am NOT currently pregnant<br>I … ❑ currently have menses ❑ currently DO NOT have menses<br>My menses… ❑ are regular ❑ are NOT regular<br>_____age of first menses _____age when menopause began<br>Date of last menstrual period ____/____/____<br>If you have been pregnant in the past, please fill in the appropriate information below.<br>_____Number of complicated pregnancies _____Number of uncomplicated pregnancies<br>_____Number of C-sections _____Number of vaginal deliveries<br>_____Number of miscarriages _____Number of terminated pregnancies |
| Male | ❑ None/N/A ❑ burning urination ❑ frequent urination ❑ prostate problems<br>❑ erectile dysfunction ❑ hesitancy/dribbling ❑ urine retention/incontinence |
| Sexual Health | Do you have any concerns about your sexual health? ❑ Yes ❑ No<br>Are you or have you ever been a victim of domestic or sexual abuse? ❑ Yes ❑ No |
| Skin | ❑ None ❑ change in skin color ❑ history of skin disorders ❑ rash<br>❑ change in nail texture ❑ hair loss ❑ itching ❑ skin lesions/ulcers<br>❑ hives ❑ numbness ❑ varicosities |
| Nervous System | ❑ None ❑ limb weakness ❑ seizures ❑ stroke<br>❑ dizziness ❑ loss of consciousness ❑ sleeps disturbance ❑ unsteadiness of gait/loss of balance<br>❑ facial weakness ❑ loss of memory ❑ slurred speech<br>❑ headache ❑ numbness ❑ stress |
| Psychological | ❑ None ❑ bi-polar disorder ❑ depression ❑ memory loss<br>❑ anxiety ❑ confusion ❑ insomnia ❑ mood change<br>❑ behavioral change ❑ convulsions ❑ loss or change of appetite |
| Hematologic | ❑ None ❑ bleeding ❑ blood transfusion ❑ fatigue<br>❑ anemia ❑ blood clotting ❑ bruising easily ❑ lymph node swelling |

Please check the appropriate response. If you are not sure, check the "?" box.

| No | Yes | ? | |
|---|---|---|---|
| ❑ | ❑ | ❑ | Do you have a past history of cancer? |
| ❑ | ❑ | ❑ | Have you had any unexplained weight loss? |
| ❑ | ❑ | ❑ | Your pain does **not** improve with rest? |
| ❑ | ❑ | ❑ | Are you over 50 years old? |
| ❑ | ❑ | ❑ | Failure to respond to a course of conservative care (4-6 weeks)? |
| ❑ | ❑ | ❑ | Have you had spinal pain greater than 4 weeks? |
| **No** | **Yes** | **?** | |
| ❑ | ❑ | ❑ | Prolonged use of corticosteroids (such as organ transplant Rx)? |
| ❑ | ❑ | ❑ | Intravenous drug use? |
| ❑ | ❑ | ❑ | Current or recent urinary tract, respiratory tract or other infection? |
| ❑ | ❑ | ❑ | Immunosuppression medication and/or conditions? |
| ❑ | ❑ | ❑ | Are you currently or have you used blood thinners? |
| **No** | **Yes** | **?** | |
| ❑ | ❑ | ❑ | History of significant trauma? |
| ❑ | ❑ | ❑ | Minor trauma in person >50 years old? |
| ❑ | ❑ | ❑ | Do you have osteoporosis (weak bones)? |
| ❑ | ❑ | ❑ | Are you over 70 years old? |
| ❑ | ❑ | ❑ | Any history of prolonged use of corticosteroids? |
| **No** | **Yes** | **?** | |
| ❑ | ❑ | ❑ | Acute onset urinary tract retention or overflow incontinence (wet underwear)? |
| ❑ | ❑ | ❑ | Loss of anal sphincter tone or fecal incontinence (bowel accidents)? |
| ❑ | ❑ | ❑ | Saddle anesthesia (numbness in the groin region)? |
| ❑ | ❑ | ❑ | Global or progressive muscle weakness in the legs (legs give out)? |

PRECISION
CHIROPRACTIC

# Family History

| **Relation** | **Age** (now or at death) | | | **Serious illness/cause of death** |
|---|---|---|---|---|
| Father | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Paternal grandfather | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Paternal grandmother | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Mother | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Maternal grandfather | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Maternal grandmother | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Brother(s) | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Sister(s) | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Son(s) | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |
| Daughter(s) | | ❑ alive ❑ deceased | ❑ no significant disease<br>❑ has/had_____ | |

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at the Palmer Clinics at this time.

Patient Signature Date

Signature of Parent or Legal Guardian Relationship



**Patient Initials _____**