Chiropractic Patient History Questionnaire

Date:_____

Name:_____ Date of birth: _____

Address:_____City: _____ St:_____ Zip: _____

Phone: (home) _____ (cell) _____ (work) _____

May we leave phone messages for you at the above phone numbers? □ Yes □ No

May we send appointment reminders to you via text messages on your cell phone for? □ Yes □ No

Email: _____

May we contact you via mail or email with newsletters/special offers? □ Yes □ No

May we contact you via email regarding your care? □ Yes □ No

How did you hear about our practice: _____

Gender: □ M □ F Relationship: □ Single □ Married/Partnership □ Divorced □ Widowed □ Separated

Spouse/Partner Name: _____

Emergency Contact:_____Phone: _____

Name of Primary Care Physician (PCP):_____Phone: : _____

PCP's Address:_____City: _____ St:_____ Zip: _____

Insurance Company Name:_____ ID #: _____

Who is the insurance under:_____ His/Her Date of Birth: _____/____/_____

Your Occupation:_____ Your Employer: _____

I choose to decline receipt of my clinical summary after every visit. These summaries are often blank as a result of the nature and frequency of chiropractic care. □ Yes □ No

Patient Signature: _____ Date: _____

Carriage House Chiropractic and Acupuncture *Patient Name:* _____

What complaint brings you in today? _____

_____

_____

Have you seen any other providers for today's complaint(s)? **Yes** **No** If yes, Provider's name and specialty:

_____

_____

What types of treatment(s) have you received, if any, for your presenting complaint(s)? **None**

_____

_____

Have you had any tests (X-rays, MRI, CT, Lab work) for this or other current complaint(s)? **Yes** **No** If yes, describe:

_____

Please complete the following for your complaint.

Please rate your symptoms on a scale of 0-10 (10 being the most severe symptoms you've ever experienced):

(circle) **No Symptoms** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **Worst Symptoms**

How often do you have the symptoms?: (circle)

Occasionally **(0-25% of the time)** **Intermittently** **(26-50%)** **Frequently** **(51-75%)** **Constantly** **(75-100%)**

Please describe the symptoms you are feeling?: (circle)

Sharp/Stabbing **Ache** **Dull** **Burning** **Throbbing** **Numbness** **Tingling** **Cramping**

How did the symptoms start?: _____

When did the symptoms start?: _____

What makes the symptoms worse?: _____

What makes the symptoms better?: _____

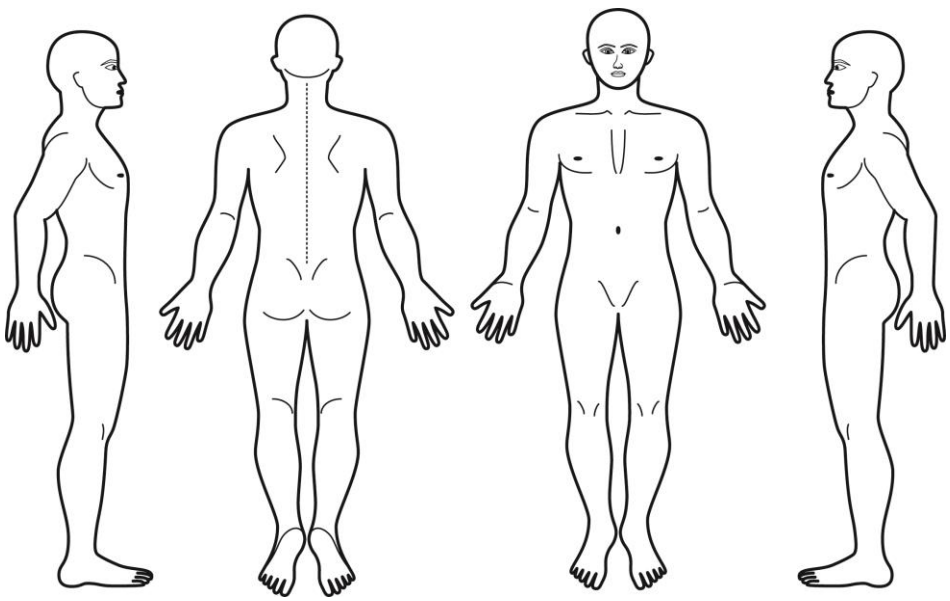
Do the symptoms travel? _____ If so, where?: _____

Are the symptoms worse in the: **Morning** **Mid-Day** **Afternoon** **Evening** **Night** **While Sleeping**

Have you had these symptoms before? Yes No If Yes: Please describe when: _____

Please mark your symptoms on the Drawing to the right using the following Letters to describe your symptoms

A Dull Ache/Throb
S Sharp/Stabbing
B Burning
N Numbness
C Cramping
T Tightness



Overall Health

Height (in feet or inches): _____ Weight (in lbs): _____

Smoking Status: ☐ Smoke Everyday ☐ Smoke Some Days ☐ Former Smoker ☐ Never Smoked

Do you use any other tobacco products? **Yes** **No** If yes, what type? :_____

How much?_____ How long?_____ Have you ever tried quitting? **Yes** **No**

If you quit, when? _____ Why?:_____

Current Medications: _____

_____

Current Supplements/Vitamins: _____

_____

Allergies: Please list all allergies (Seasonal, Food, Medications):

_____

_____

Please list other medical/health problems you may be seeing other providers for: (Please list issue and provider.)

_____

_____

Have you ever had X-rays, MRI or CT or any other tests (e.g., EKG, blood work) for the other medical problems you are being treated for? **Yes** **No** If yes, list below:

Study/Test: _____ Date: _____ Treatment received: _____

Study/Test: _____ Date: _____ Treatment received: _____

Have you ever been hospitalized or had surgery? **Yes** **No** If yes, please describe:

_____

_____

Female Only

Are you pregnant?/Is there a chance that you are pregnant? **Yes** **No** Are you currently breast feeding? **Yes** **No**

Date of last period: _____

Number of Days in cycle: _____

Number of Pregnancies: _____

Number of Deliveries: _____

Were the Deliveries: C-Section or Vaginal

Do you have any of the following?

Yes	Condition
○	Painful period
○	Excessive cramping
○	PMS symptoms
○	Missed periods
○	Irregular cycle
○	Low back pain with period
○	Complicated deliveries
○	Uterine Cysts, fibroids
○	Lumps in Breasts

Please complete the follow list by marking if you have the listed condition/complaint in the past and/or currently

Past	Present	Condition
○	○	Neck pain
○	○	Upper back pain
○	○	Mid back pain
○	○	Low back pain
○	○	Shoulder pain
○	○	Elbow/upper arm pain
○	○	Wrist/Hand pain
○	○	Hip/upper leg pain
○	○	Knee pain
○	○	Ankle/Foot Pain
○	○	Jaw pain
○	○	Joint swelling/stiffness
○	○	Thoracic Outlet Syndrome
○	○	Abnormal Weight gain/loss
○	○	Abdominal Pain
○	○	Migraine Headache
○	○	Tension Headache
○	○	Cluster Headache

Past	Present	Condition
○	○	Asthma
○	○	Angina/Chest Pain
○	○	Bladder Infection
○	○	Chronic Sinusitis
○	○	Depression/Anxiety
○	○	Dermatitis/Eczema
○	○	Dizziness/Vertigo
○	○	Excessive thirst
○	○	Frequent Urination
○	○	General Fatigue
○	○	High blood pressure
○	○	Hormone Therapy
○	○	Liver/Gall Bladder
○	○	Low blood sugar
○	○	Loss of Bladder Control
○	○	Painful Urination
○	○	Prostate Problems
○	○	Erectile Dysfunction

Past	Present	Condition
○	○	Stroke
○	○	Ulcer
○	○	Anemia
○	○	Arthritis
○	○	Diabetes
○	○	Epilepsy
○	○	Heart attack
○	○	Hepatitis
○	○	HIV/AIDS
○	○	Kidney Stones
○	○	Multiple Sclerosis
○	○	Parkinson's
○	○	Polio
○	○	Rheumatic fever
○	○	Lupus
○	○	Tuberculosis
○	○	Cancer
○	○	Tumor

Do you have any symptoms or complaints related to the following systems not listed above:

Cardiovascular: _____

Respiratory: _____

Eyes/Ears/Nose/Throat: _____

Gastrointestinal: _____

Genitourinary: _____

Family History

Do you have any children? **Yes** **No** If yes, please list their gender(s) and age(s): _____

_____

Do your children have any major medical problems (past or present)? **Yes** **No** If yes, please describe:

_____

Do you have any siblings? **Yes** **No** Do/did they have any major medical problems? **Yes** **No**
If yes, please describe: _____

_____

Are your parents still living? **Yes** **No** Do/did they have any major medical problems? **Yes** **No**
If yes, please describe: _____

_____

Are your grandparents still living? **Yes** **No** Do/did they have any major medical problems? **Yes** **No**
If yes, please describe: _____

_____

General Health Questions

Drink Alcoholic Beverages? **Yes** **No** If yes, how much do you drink per week?: _____

Have a history significant for recreational drug use? **Yes** **No** If yes, describe: _____

My diet is: **balanced** **not balanced.** My recreation is: **sufficient** **insufficient**.

My rest is: **sufficient** **insufficient.** My family stress is: **severe** **moderate** **minimal** **none.**

How do you like your work? **above average** **average** **below average** **N/A.**

My job stress is: **severe** **moderate** **minimal** **none** **N/A.**

What CHCAA services/products interest you in meeting your health goals?

____ Chiropractic ____ Soft Tissue Techniques ____ Graston Technique ____ Ergonomics

____ Exercises ____ Supplements/Vitamins ____ Nutritional Counseling ____ Acupuncture

____ Homeopathy ____ PowerLift Training ____ Other (please describe below):

I have read and completed all answers to the above questions to the best of my knowledge. I understand that failure to properly disclose all appropriate health history may hinder my health care provider's ability to properly diagnose and treat my complaints. I will, on all future visits, inform my health care provider of changes in my health status.

Your signature _____ Date _____

Provider's signature _____ Date _____

Thank you for completing this form. The information you have provided will help us in attending to your healthcare needs.