

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Reason for visit/ Chief Complaint: _____

- Is this injury the result of a motor vehicle accident? Yes No
- Is this injury work-related? Yes No
- Have you been treated for this complaint before? Yes No
- Have you been treated by a chiropractor before? Yes No
- Is there any chance you are pregnant? (*Females only*) Yes No

PAST MEDICAL HISTORY

Please check YES, or NO if you either *have* or *had* any of the following conditions.

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS/ HIV | <input type="checkbox"/> | <input type="checkbox"/> | Fractures | <input type="checkbox"/> | <input type="checkbox"/> | Stroke/TIA |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Condition |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Tumors/Growths |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleed Easily | <input type="checkbox"/> | <input type="checkbox"/> | Herniated Disc | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer:
Type: _____ | <input type="checkbox"/> | <input type="checkbox"/> | High Blood
Pressure | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Prostate
Problems | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | STD's | | | |

Exercise

- None
- Minimal
- Moderate
- Intense

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking Packs/Day _____
- Alcohol Drinks/Week _____
- Caffeine Drinks Drinks/ Day _____
- High Stress Levels Reason: _____