

Patient Health Survey

About You

Name: _____
Address: _____
City: _____ State: _____
Zip Code: _____ Home Phone: _____
Cell Phone: _____
Email Address: _____

Date of Birth: _____ Age: _____
Social Security Number: _____
Gender: Female Male
Number of Children: _____
Marital Status: Divorced Married
 Single Widowed

Employer Name: _____
Employer Address: _____
Employer City: _____ Employer State: _____
Employer Zip Code: _____ Work Phone: _____
Position/Title: _____

Reason For This Visit

Describe the reason for this visit: _____
Is the purpose of this appointment related to:
 Job Sports Auto Fall Home Injury Chronic Discomfort Other
Please explain: _____
If job related, have you made a report of your accident to your employer? Yes No
When did this condition begin? _____ Has this condition: Gotten worse Stayed constant Come and gone
Does this condition interfere with? Work Sleep Daily routine Other activities
Please explain: _____
Has this condition occurred before? Yes No Please explain: _____
Have you seen other doctors for this condition? Yes No Doctors Name: _____
Type of treatment: _____ Results: _____

How Did Your Hear About Us

Who referred you to our office? _____
Have you seen or heard of our office because of (check all that apply):
 Newspaper Sign Yellow Pages
 Community Event Mailing
Have you been treated by a chiropractor before?
 Yes No
If yes, what was the reason for the visit? _____
Approximate date of last visit? _____

Health Habits

Do you smoke? Yes No
Do you drink alcohol? Yes No
Do you drink coffee, tea or soda? Yes No
Do you exercise regularly? Yes No
Do you wear? Heel lifts Sole lifts
 Inner soles Arch supports

Patient Health Survey

Patient # _____

Height _____ Weight _____

Full Name

Age _____ Date _____

Have you ever (at any time) experienced any of the following?

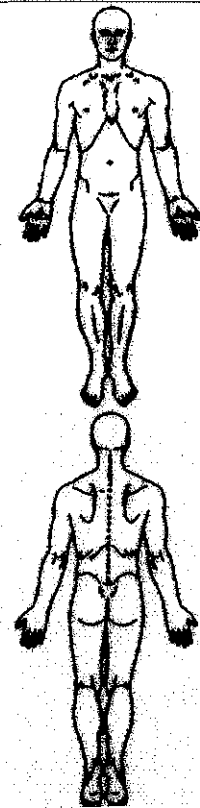
- | | | | | | |
|-----------------------------------|-------------------------|-------------------------|---------------------------------------|-------------------------|-------------------------|
| Difficulty urinating | <input type="radio"/> Y | <input type="radio"/> N | Claustrophobia (fear of small spaces) | <input type="radio"/> Y | <input type="radio"/> N |
| Loss of bladder control | <input type="radio"/> Y | <input type="radio"/> N | Spinal surgery | <input type="radio"/> Y | <input type="radio"/> N |
| Loss of bowel control | <input type="radio"/> Y | <input type="radio"/> N | Common cold/flu | <input type="radio"/> Y | <input type="radio"/> N |
| Temporary loss of vision, one eye | <input type="radio"/> Y | <input type="radio"/> N | Carotid artery surgery | <input type="radio"/> Y | <input type="radio"/> N |
| Blood in urine | <input type="radio"/> Y | <input type="radio"/> N | Breast removal | <input type="radio"/> Y | <input type="radio"/> N |

Have you ever been diagnosed with or told you have one of the following?

- | | | | | | |
|---|-------------------------|-------------------------|---------------------------|-------------------------|-------------------------|
| Detached retina | <input type="radio"/> Y | <input type="radio"/> N | Rheumatoid arthritis | <input type="radio"/> Y | <input type="radio"/> N |
| Stroke | <input type="radio"/> Y | <input type="radio"/> N | Fractured/broken vertebra | <input type="radio"/> Y | <input type="radio"/> N |
| Slipped disc | <input type="radio"/> Y | <input type="radio"/> N | Bleeding disorders | <input type="radio"/> Y | <input type="radio"/> N |
| Herniated disc | <input type="radio"/> Y | <input type="radio"/> N | High blood pressure | <input type="radio"/> Y | <input type="radio"/> N |
| Osteoporosis | <input type="radio"/> Y | <input type="radio"/> N | Blood in stool | <input type="radio"/> Y | <input type="radio"/> N |
| TIA's (pin or mini strokes) | <input type="radio"/> Y | <input type="radio"/> N | Cancer | <input type="radio"/> Y | <input type="radio"/> N |
| Drop attacks (collapsing, but not fainting) | <input type="radio"/> Y | <input type="radio"/> N | AIDS | <input type="radio"/> Y | <input type="radio"/> N |
| Hardening of the arteries | <input type="radio"/> Y | <input type="radio"/> N | Kidney disease | <input type="radio"/> Y | <input type="radio"/> N |
| Partial or complete paralysis | <input type="radio"/> Y | <input type="radio"/> N | Prostate disease | <input type="radio"/> Y | <input type="radio"/> N |

In the past 14 days (2 weeks), have you experienced any of the following?

- | | | | | | |
|--------------------------------------|-------------------------|-------------------------|----------------------------|-------------------------|-------------------------|
| Nausea | <input type="radio"/> Y | <input type="radio"/> N | Memory loss | <input type="radio"/> Y | <input type="radio"/> N |
| Vomiting | <input type="radio"/> Y | <input type="radio"/> N | Fever | <input type="radio"/> Y | <input type="radio"/> N |
| Vertigo (spinning) | <input type="radio"/> Y | <input type="radio"/> N | Recurrent headaches | <input type="radio"/> Y | <input type="radio"/> N |
| Difficulty walking | <input type="radio"/> Y | <input type="radio"/> N | Diarrhea | <input type="radio"/> Y | <input type="radio"/> N |
| Incoordination | <input type="radio"/> Y | <input type="radio"/> N | Skin rash/infection | <input type="radio"/> Y | <input type="radio"/> N |
| Loss of consciousness | <input type="radio"/> Y | <input type="radio"/> N | A major fall | <input type="radio"/> Y | <input type="radio"/> N |
| Double vision | <input type="radio"/> Y | <input type="radio"/> N | A minor fall | <input type="radio"/> Y | <input type="radio"/> N |
| Blurred vision | <input type="radio"/> Y | <input type="radio"/> N | An auto accident | <input type="radio"/> Y | <input type="radio"/> N |
| Speech problems | <input type="radio"/> Y | <input type="radio"/> N | A work injury | <input type="radio"/> Y | <input type="radio"/> N |
| Clumsiness | <input type="radio"/> Y | <input type="radio"/> N | Head trauma | <input type="radio"/> Y | <input type="radio"/> N |
| Loss of strength | <input type="radio"/> Y | <input type="radio"/> N | Tinnitus (ringing in ears) | <input type="radio"/> Y | <input type="radio"/> N |
| Abnormal menstruation | <input type="radio"/> Y | <input type="radio"/> N | Painful bowel movements | <input type="radio"/> Y | <input type="radio"/> N |
| Numbness or other sensory complaints | <input type="radio"/> Y | <input type="radio"/> N | | | |



Medication You Take

- | | |
|--|---|
| <input type="checkbox"/> Cholesterol Medications | <input type="checkbox"/> Blood Pressure Medicine |
| <input type="checkbox"/> Stimulants | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Pain Killers (including aspirin) |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Other |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Other |

Vitamins & Supplements

Please list Other Medications

Health Conditions

Instructions: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect your customized care plan and the possibility of being accepted for care.

- | | |
|---|--|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Loss of Sleep |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain in Arms/Legs/Hands |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Low Blood Pressure |

Your Concerns

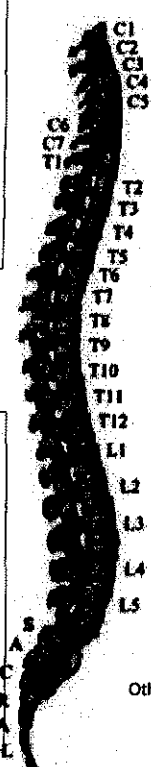
Instructions: Please check box for only the health concerns or conditions you may be experiencing now or in the past. Each area of concern relates to an area of the spine and nerve function.

-
- Sore throat
-
-
- Stiff neck
-
-
- Radiating arm pain
-
-
- Hand/finger numbness
-
-
- Asthma
-
-
- Allergies
-
-
- Heart condition
-
-
- High blood pressure

-
- Headaches
-
-
- Migraines
-
-
- Dizziness
-
-
- Sinus problems
-
-
- Allergies
-
-
- Fatigue
-
-
- Head colds
-
-
- Vision problems
-
-
- Hearing problems
-
-
- Difficulty concentrating

-
- Constipation
-
-
- Colitis
-
-
- Diarrhea
-
-
- Gas Pain
-
-
- Irritable bowel
-
-
- Bladder Problems
-
-
- Menstrual problems
-
-
- Low back pain
-
-
- Leg pain or numbness
-
-
- Reproductive problems

-
- Middle back pain
-
-
- Congestion
-
-
- Difficulty breathing
-
-
- Bronchitis
-
-
- Pneumonia
-
-
- Gallbladder condition
-
-
- Stomach problems
-
-
- Ulcers
-
-
- Gastritis
-
-
- Kidney problems



Other:

Health Conditions - For Women Only

Are you pregnant? Yes No

If yes, when is your due date? _____

Are you nursing? Yes No

Are you taking birth control? Yes No