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Dear Patient:

Thank you for your visit today. In order to provide you with holistic care and address the root cause of your health concerns, we would like you to complete a detailed and comprehensive health questionnaire. Your answers will help you achieve better treatment results. The more you are willing to share with us, the better we can treat the root cause of your health conditions and symptoms.

Patient's Name: _____ Date: _____

Doctor's Name _____ Referred By _____ Date _____ File #: _____

PATIENT HEALTH HISTORY **Re-evaluation:** []Yes

1. Name: _____ Gender: []M, []F Age: _____ Height: _____ Weight: _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: _____ Home Phone _____ Birth Date _____
Email _____
Primary Physician: _____ Phone: _____ Fax: _____

2. Have you ever used: []Chiropractic Treatment []Chinese Herbal Medicine []Acupuncture []Homeopathy
If yes, for which conditions? _____
If no, would you like to hear about options for your condition (please circle)? Yes No

3. What is the reason for your visit? What is your chief complaint? (Describe your condition at its worst)

Other Complaints: _____
Diagnosed Medical Conditions: _____

4. Cause of Health Conditions: [] Injury [] Auto Accident [] Personal Injury [] Other: _____
Has the accident been reported? Yes No Reported to: []Employer []Auto Carrier []Other: _____
Are you now or have you ever been disabled? Yes No Date: _____ Cause: _____
Have you ever retained an attorney? Yes No Name: _____ Phone: _____

5. Pain Symptoms: a. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____
(In Order b. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____
of Severity) c. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____

6. Please circle areas of pain or discomfort and mark them using the codes listed below:
N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars

List the frequency and severity of your condition on a scale of 1 to 5:

- | | |
|--------------------|---------------------------------|
| Frequency: | Severity: |
| 1=20% of the time | 1=Annoying |
| 2=40% of the time | 2=Impairment to Activity |
| 3=60% of the time | 3=Need Medication |
| 4=80% of the time | 4=Impairment with Medication |
| 5=100% of the time | 5=Severe (Need Hospitalization) |

Location/Body Part	Frequency	Severity	Initial Cause	Getting Worse?	
a. _____	_____	_____	_____	Yes	No
b. _____	_____	_____	_____	Yes	No
c. _____	_____	_____	_____	Yes	No

Does it affect other areas of your body (please circle)? Yes No
If yes, explain: _____

7. Do you have, or have you ever had:
Osteoarthritis ___ Bone Spurs ___ Non-union Fracture ___ Ganglion or Baker's Cyst ___
Bulging Disc ___ Tendonitis ___ Avascular Necrosis ___ Cartilage injury ___
Herniated Disc ___ Joint Separations ___ Post-herpetic neuralgia ___ (Meniscus Tear, Chondromalacia
DDD ___ Bursitis ___ Intercostal Neuralgia ___ Patellar Syndrome)
Stenosis ___ Sprains ___ Morton's Neuroma ___

8. Does the condition interfere with (please check): Work Sleep Other: _____
Please describe: _____
Without treatment, how would it affect your quality of life? _____

- ___ Blood in Stool
- ___ Mucous in Stool
- ___ Black Stool
- ___ Stomach Pains/Cramps
- ___ Abdominal Pain
- ___ Abdominal Spasms
- ___ Lack of Bowel Control
- ___ Itchy Anus
- ___ Rectal Pain
- ___ Hemorrhoids
- ___ Anal Fissures

- Bowel Movements:
 Frequency _____
 Color _____
 Texture/Form _____
 Odor _____

General

- ___ Sweat Easily
- ___ Night Sweats
- ___ Gall Bladder Trouble
- ___ Cold Hands or Feet
- ___ Poor Circulation
- ___ Spitting Blood
- ___ Fever
- ___ Chills
- ___ Muscle Cramps
- ___ Lower Extremity Edema
- ___ Vertigo or Dizziness
- ___ Bleed or Bruise Easily
- ___ Frequent Illness
- ___ Seasonal Allergy
- ___ Addicted to Drugs
- ___ Addicted to Smoking
- ___ Peculiar Taste:
 Describe: _____

Respiratory

- ___ Tight Chest
- ___ Shortness of Breath
- ___ Difficulty Breathing
 When Lying Down
- ___ Itching Inside the Chest
- ___ Wheezing
- ___ Persistent Cough
- ___ Coughing Blood
- ___ Cough: Wet / Dry, Thick / Thin
 Color of Phlegm _____
- ___ Other Lung Problems

Urinary

- ___ Bedwetting
- ___ Blood in Urine
- ___ Lack of Bladder Control
- ___ Pain During Urination
- ___ Frequent/urgent urination
- ___ Incomplete Urination
- ___ Wake to Urinate
- ___ Prostate Problem
- ___ Genital Itch or Discharge
- ___ Premature Ejaculation
- ___ Recurrent Bladder Infections
- ___ Impotence
- ___ Increased Libido
- ___ Decreased Libido

Weight & Eating

- ___ Recent Weight Loss
- ___ Recent Weight Gain
- ___ Binge Eating/Drinking

- ___ Craving Certain Foods
 Describe: _____
- ___ Excessive Weight
- ___ Loss of Taste
- ___ Compulsive Eating
- ___ Poor Appetite
- ___ Heavy Appetite
- ___ Strongly Like Cold Drinks
- ___ Strongly Like Hot Drinks
- ___ Water Retention

Musculoskeletal

- ___ Muscle Pains
- ___ Muscle Cramps
- ___ Pains or Aches in Joints
- ___ Stiffness/Limited Range of Motion
- ___ Pains or Aches in Muscles
- ___ Feeling of Weakness/Tiredness
- ___ Swollen Tender Joints
- ___ Pain in Legs
- ___ Hip Tightness/Coldness/Pain
- ___ Rib Pain
- ___ Neck/Shoulder Pain
- ___ Upper Back Pain
- ___ Back Pain
- ___ Lower Back Pain
- ___ Sciatic Pain

Cardiovascular

- ___ Heart Murmur
- ___ Heart Palpitations
- ___ Irregular or Skipping Heartbeat
- ___ Rapid or Pounding Heartbeat
- ___ Chest Pain
- ___ Difficulty Breathing
- ___ High Blood Pressure
- ___ Low Blood Pressure
- ___ Blood Clots
- ___ Anemia
- ___ Fainting
- ___ Tachycardia

Emotions

- ___ Mood Swings
- ___ Anxious, Fear, Nervous
- ___ Angry Irritable, Aggressive
- ___ Easily Stressed
- ___ Argumentative
- ___ Frustrated, Cries Easily
- ___ Depression
- ___ Abuse Survivor
- ___ Considered/Attempted Suicide
- ___ Seeing a Therapist
- ___ Obsessive Behavior
- ___ Compulsive Thoughts
- ___ Uncontrollable Urges

Mind

- ___ Poor Memory
- ___ Difficulty Completing Projects
- ___ Difficulty with Mathematics
- ___ Underachiever
- ___ Poor/Short Attention Span
- ___ Confusion
- ___ Easily Distracted
- ___ Difficulty Making Decisions
- ___ Learning Disability

Neurological

- ___ Seizures

- ___ Numbness
- ___ Tics
- ___ Foot Neuropathy

Energy & Activity

- ___ Apathy, Lethargy
- ___ Attention Deficit
- ___ Fatigue
- ___ Lack of Strength
- ___ Body Heaviness
- ___ Hyperactivity
- ___ Restlessness
- ___ Shortness of Breath
- ___ Stuttering or Stammering
- ___ Slurred Speech

Ears

- ___ Itchy Ears
- ___ Ear Aches, Ear Infections
- ___ Drainage from Ears
- ___ Hearing Loss
- ___ Reddening of the Ears
- ___ Ringing in the Ears
- ___ Headaches
- ___ Concussions

Nose

- ___ Stuffy Nose
- ___ Dryness Inside the Nose
- ___ Chronically Red,
 Inflamed Nose
- ___ Sinus Problem
- ___ Hay Fever
- ___ Sneezing Attacks
- ___ Excessive Mucous Formation
- ___ Back Dripping
- ___ Nose Bleeding

Eyes

- ___ Glasses/Contacts
- ___ Watery or Itchy Eyes
- ___ Red, Swollen or Sticky Eyelids
- ___ Bags/Dark Circles Under Eyes
- ___ Poor Vision
- ___ Blurred or Tunnel Vision
- ___ Sensitive to Sunlight
- ___ Eye Strain
- ___ Eye Pain
- ___ Red Eyes
- ___ Itchy Eyes
- ___ Easily Fatigued Eyes
- ___ Spots in Eyes
- ___ Night Blindness
- ___ Glaucoma
- ___ Cataract

Head

- ___ Headaches
- ___ Migraines
- ___ Faintness
- ___ Dizziness
- ___ Facial Flushing
- ___ Facial Pain
- ___ TMJ

Sleep

- ___ Insomnia
- ___ Sleep Disorder
- ___ Difficulty Falling Asleep
- ___ Difficulty Staying Asleep

- ___ Wakes Up Frequently
- ___ Morning Shakiness
- ___ Cannot Wake Up in Morning

Mouth & Throat

- ___ Chronic Coughing
- ___ Gagging, Often Clearing Throat
- ___ Sore Throat, Hoarse, Voice Loss
- ___ Swollen/Discolored Tongue/Lips
- ___ Sores on Lips or Tongue
- ___ Canker Sores
- ___ Itching on Roof of Mouth
- ___ Dry Mouth
- ___ Excessive Saliva
- ___ Recurrent Sore Throat
- ___ Excessive Phlegm
 Color: _____
- ___ Swollen Glands
- ___ Lumps in Throat
- ___ Enlarged Thyroid
- ___ Teeth Problem
- ___ Gum Problem
- ___ Grinding Teeth

Skin & Hair

- ___ Acne
- ___ Itching
- ___ Hives
- ___ Rash
- ___ Eczema
- ___ Dry Skin
- ___ Ulcerations
- ___ Hair Loss
- ___ Dandruff
- ___ Flushing or Hot Flashes
- ___ Change in Hair/Skin Texture
- ___ Loss in Pigmentation
- ___ Skin Fungal Infections

For Women Only

- Age Menstrual Cycle Began: _____
- Length of Cycle (Day 1 - Day 1): _____
- Duration of Flow: _____
- ___ Dark Color Flow
- ___ Clots in Flow
- ___ Excessive Flow
- ___ Irregular Circle
- ___ Painful Period
- ___ Painful Intercourse
- ___ Excessive Vaginal Discharge
- ___ Menopause Symptoms
- ___ Lump in Breast
- ___ Vaginal Dryness
- ___ Vaginal Sores
- ___ Vaginal Odor
- Vaginal Discharge Color: _____
- # of Pregnancies: _____
- # of Live Births: _____
- # of Premature Births: _____
- Age at Menopause: _____
- Date Last Period Began: _____

Any Other Symptoms:

- _____
- _____

17. Operations and Procedures

Date		Date		Date		Other: _____
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus	Date: _____
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia	
_____	Gall Bladder	_____	Gynecological	_____	Thyroid	
_____	Back Operation	_____	Rectal Surgery	_____	Stomach	

List and date any accidents or falls (please check):

Car _____, Recreation _____, Sports _____, School _____, Other _____

List any broken bones: _____

Have you ever had spinal taps or spinal injections (please check)? Yes No Date: _____

Have you ever lost consciousness (please check)? Yes No Why? _____

Have you ever had X-ray taken? Yes No Date: _____ By Whom? _____

For what ailment were these X-rays taken? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The health care provider's office will prepare necessary paperwork to assist me in the filling insurance claims but cannot guarantee reimbursement. Direct payments made from the insurance company to the health care provider's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payments for these services to the health care provider's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collections of the account.

I authorize the health care provider to examine and treat my condition as deemed appropriate through the use of chiropractic care, acupuncture, Traditional Chinese Medicine, and/or other natural healing methods.

Patient's / Guardian's Signature: _____ **Date:** _____