CHIROPRACTIC HEALTH QUESTIONNAIRE

PLEASE CHECK THE SYMPTOMS THAT YOU HAVE EXPERIENCED RECENTLY:

GENERAL HEALTH

- ☐ Allergies
- ☐ Dizziness
- ☐ Convulsions
- ☐ Fatigue
- ☐ Fainting
- ☐ Fever/Chills
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Anxiety
- ☐ Numbness
- ☐ Sweats
- ☐ Weakness in arms/legs

MUSCULOSKELETAL

- ☐ Low Back Pain
- ☐ Neck Pain/Stiffness
- ☐ Pain between Shoulders
- ☐ Arm/Shoulder Pain
- ☐ Knee Pain
- ☐ Foot Pain
- ☐ Hip Pain
- ☐ Jaw Clicking/Pain
- ☐ Faulty Posture
- ☐ Swollen Joints
- ☐ Arthritis

EYES/EARS/NOSE/THROAT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Ear Aches
- ☐ Ear Infections
- ☐ Hearing Difficulty
- ☐ Sore Throat
- ☐ Sinus Problems
- ☐ Nasal Congestion
- ☐ Thyroid Problems
- ☐ Frequent Colds
- ☐ Nose Bleeds

CARDIOVASCULAR/ RESPIRATORY

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Blood Pressure Problems
- ☐ Varicose Veins
- ☐ Irregular Heart Beat
- ☐ Poor Circulation
- ☐ History of Stroke
- ☐ Poor Circulation
- ☐ Chest Pain
- ☐ Chronic Cough

GASTRO-INTESTINAL

- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Poor/Excessive Appetite
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Heartburn

GENITO-URINARY

- ☐ Bed Wetting
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Kidney Infection
- ☐ Prostate Problems
- ☐ Urinary Tract Infection

FOR WOMEN ONLY

- ☐ Menstrual Cramps
- ☐ Menstrual Irregularity
- ☐ Hot Flashes
- ☐ Menopause Symptoms
- ☐ Lumps in Breasts
- ☐ Excessive Flow

Are you currently pregnant?

- ☐ Yes
- ☐ No

CHIROPRACTIC HEALTH QUESTIONNAIRE

HAVE YOU HAD ANY OF THE FOLLOWING:

☐ Alcoholism	☐ Cancer	☐ Diabetes
☐ Chicken Pox	☐ Heart Attack	☐ Pneumonia
☐ Epilepsy	☐ Rheumatic Fever	☐ Tuberculosis

Do you have a history of any other significant illness? Please list below.

____

Please list any falls, accidents or injuries that you have had in the past:

____

____

Have you ever been unconscious?

- ☐ Yes
- ☐ No

Are you taking any medication?

- ☐ Yes
- ☐ No

Have you ever had surgery? If yes, please explain.

____

Have you ever been hospitalized? If yes, please explain.

____

Have you ever had a mental disorder or nervous breakdown? _________________________

HABITS

Coffee/Tea	☐ Heavy	☐ Moderate	☐ Light
Tobacco	☐ Heavy	☐ Moderate	☐ Light
Alcohol	☐ Heavy	☐ Moderate	☐ Light
Sleep	☐ Heavy	☐ Moderate	☐ Light