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Name: ____________________ Date: ______________

Health History Questionnaire

Reason for this visit: ______________________________

Have you had this problem in the past? ☐ yes ☐ no Explain: ______________

When did the symptoms begin? ______________________________

Is it getting worse? ☐ yes ☐ no Is it constant? ☐ yes ☐ no

Describe the pain: ______________________________

Does it interfere with: ☐ work ☐ school ☐ sleep ☐ daily routine ☐ recreation

Is it painful to: ☐ sit ☐ walk ☐ bend ☐ lie down ☐ lift objects

Have you been treated for this problem before? ☐yes ☐no If yes, by whom? ______________

What was recommended? ______________________________

What other health care professionals have you seen? ☐ Medical Doctor ☐ Doctor of Chiropractic ☐ Physical Therapist ☐ Osteopath ☐ Massage Therapist ☐ Acupuncturist

What activities do you typically do during the day? ______________________________

Is this condition affecting your ability to perform these activities? ☐yes ☐ no

Please explain: ______________________________

Have you received chiropractic care in the past? ☐yes ☐ no When? ______________

Name of Chiropractor: ______________ Reason for previous care: ______________

Current Medical Doctor: ______________________________

Do you .....

Exercise? ☐yes ☐ no How many times per week? _____ What type of exercise? ______________

Sleep well? ☐yes ☐ no How many hours at a time? _______ Waterbed? ☐yes ☐ no

Use any orthotics, shoe lifts, arch supports, etc.? ☐yes ☐ no If yes, explain: ______________

Smoke? ☐yes ☐ no How much? _________ Drink alcohol? ☐yes ☐ no How much? _________

Use caffeine? ☐yes ☐ no How much? _________

Please fill in the following information:

Medication:	What is it for?	Who prescribed it?	List Allergies:	Surgeries:

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Please check all conditions you currently have or have had in the past:

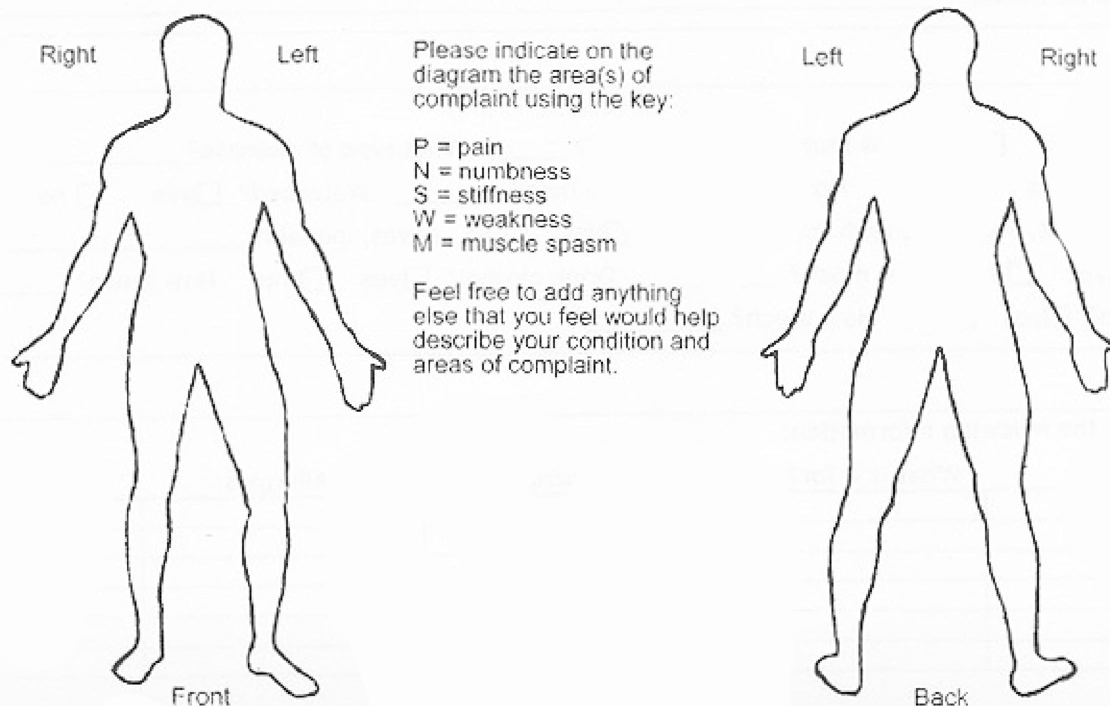
- ☐ HIV/AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia / Bulimia
- ☐ Arthritis (where? ________________)
- ☐ Anxiety
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Breast lumps
- ☐ Bronchitis
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Cancer (where? ________________)
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Fractures (where? ________________)
- ☐ Hernia
- ☐ High cholesterol
- ☐ Migraines
- ☐ Headaches
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric treatment
- ☐ Scarlet fever
- ☐ Stroke / TIA
- ☐ Suicide attempt
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic fever
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal disease (which? ____________)

Please check all symptoms that you currently have or have had in the past year:

- ☐ Chest pain / angina
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Ankle swelling
- ☐ Dizziness
- ☐ Fainting
- ☐ Bruise easily
- ☐ Confusion
- ☐ Memory problems
- ☐ Fatigue
- ☐ Insomnia
- ☐ Numbness
- ☐ Nervousness
- ☐ Unexplained weight loss / weight gain
- ☐ Fevers
- ☐ Vision changes
- ☐ Troubles sleeping
- ☐ Poor appetite
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating
- ☐ Nausea / vomiting
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Rectal bleeding
- ☐ Abdominal pain
- ☐ Frequent urination
- ☐ Inability to urinate
- ☐ Bladder infections
- ☐ Bloody urine
- ☐ Burning with urination
- ☐ Loss of bladder control
- ☐ Hives / rash
- ☐ Itching
- ☐ Changes in moles
- ☐ Non-healing sores
- ☐ Difficulty swallowing
- ☐ Earaches / discharge
- ☐ Nosebleeds
- ☐ Hay fever / allergies
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Voice changes
- ☐ Erectile dysfunction
- ☐ Lumps in testicles
- ☐ Penile discharge
- ☐ Abnormal pap smear
- ☐ Vaginal discharge
- ☐ Irregular menstrual cycles
- ☐ Menstrual pain
- ☐ Painful intercourse
- ☐ Nipple discharge

Date of last menstrual period: ________________ Date of last pap smear ________________ Are you pregnant? ________

Have you had a mammogram? __________ Do you do self breast / testicular exams? ________________



Please indicate on the diagram the area(s) of complaint using the key:

P = pain
N = numbness
S = stiffness
W = weakness
M = muscle spasm

Feel free to add anything else that you feel would help describe your condition and areas of complaint.

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