CONFIDENTIAL PATIENT QUESTIONNAIRE DATE_____

LEGAL NAME_____ DOB_____AGE_____SEX_____

ADDRESS_____SS#_____

CITY, STATE _____ZIP_____HOME PHONE_____

E-MAIL _____WORK PHONE_____

REFERRED BY? Name: _____ □ Television □ Newspaper □ Phonebook □ Web Site □ Other

Main Complaint:_____

Is your condition getting progressively worse? Yes___ No___ constant___ comes and goes ____

This condition interferes with my ability to: _____

*Have you been treated for this? Yes __ No __ Describe: _____

*Do you have any associated symptoms with this condition? (fatigue, ache, shortness of breath, etc.)

Describe:_____

Past History:

List past surgeries & dates: _____

List past illnesses & dates: _____

List past injuries/fractures & dates: _____

List past treatments & dates: _____

Current medications: _____

Does anyone in your immediate family have any similar conditions? yes__ no__ mom__ dad__ brother___ sister ___

Education: □ high school □ college □ post graduate

Exercise: □ none □ frequent and heavy □ infrequent □ limited □ occasional □ regular

Family status: □ married □ single □ divorced □ widowed ***Number of children:**_____

Race: □ African-American □ American Indian □ Caucasian □ Hispanic □ Asian □ Other _____

Occupation: _____

Work environment: Are you exposed to: □ lung pollutants □ repetitive injury □ temperature extremes

□ constant sitting □ constant standing □ heavy typing/data entry □ heavy lifting □ stress

HIV exposure: □ none □ HIV-positive □ unknown □ possible

Dental care: □ limited □ none □ regular □ dentures □ amalgam fillings □ root canal

Eye care: □ limited □ none □ regular □ require corrective lenses

Physical examination: □ irregular □ never □ regular

Do you take vitamins? □ yes □ no Describe: _____

Substance use:

Do you drink alcohol? Yes ___ No ____ Is it a problem? Yes ___ No ___

Do you use (prescription) drugs? Yes ___ No ____ Is it a problem? Yes ___ No ____

Do you smoke tobacco? Yes ___ No ____

Do you chew tobacco? Yes ___ No ____

Do you have a prescription drug addiction? Yes ___ No ____

(Please turn paper over to other side)

Review of Systems

(please circle which side is affected)

Musculoskeletal:

Painful joints: ☐ **fingers**: L R ☐ **hand**: L R ☐ **wrist**: L R ☐ **elbow**: L R
☐ **shoulder**: L R ☐ **hip**: L R ☐ **knee**: L R ☐ **ankle**: L R ☐ **foot**: L R ☐ other

Stiff joints: ☐ **fingers**: L R ☐ **hand**: L R ☐ **wrist**: L R ☐ **elbow**: L R
☐ **shoulder**: L R ☐ **hip**: L R ☐ **knee**: L R ☐ **ankle**: L R ☐ **foot**: L R ☐ other

Arthritis: ☐ **fingers**: L R ☐ **hand**: L R ☐ **wrist**: L R ☐ **elbow**: L R
☐ **shoulder**: L R ☐ **hip**: L R ☐ **knee**: L R ☐ **ankle**: L R ☐ **foot**: L R ☐ other

Muscle weakness: ☐ **hand**: L R ☐ **forearm**: L R ☐ **upper arm**: L R ☐ **shoulder**: L R
☐ **upper leg**: L R ☐ **lower leg**: L R ☐ **foot**: L R ☐ other

Night cramps: ☐ yes ☐ no Recent trauma or injury: ☐ yes ☐ no Abnormal posture: ☐ yes ☐ no

Spine problems: ☐ **neck** L R ☐ **between shoulder blades** L R ☐ **low back** L R ☐ other

Sprains: ☐ **fingers** L R ☐ **hand** L R ☐ **wrist** L R ☐ **elbow** L R ☐ **shoulder** L R
☐ **hip** L R ☐ **knee** L R ☐ **ankle** L R ☐ **feet** L R ☐ other

Swelling: ☐ **fingers** L R ☐ **hand** L R ☐ **wrist** L R ☐ **elbow** L R
☐ **shoulder** L R ☐ **hip** L R ☐ **knee** L R ☐ **ankle** L R ☐ **foot** L R ☐ other

Neurological:

☐ equilibrium problem ☐ hearing problem ☐ speech difficulty ☐ vision problem ☐ convulsions/seizures
☐ difficulty walking ☐ involuntary twitches ☐ motor skill loss ☐ stroke ☐ paralysis ☐ numbness
☐ loss of bladder control ☐ sensitive to heat/cold ☐ sweating ☐ dizziness ☐ headaches ☐ memory loss ☐ fainting
☐ head trauma ☐ sciatica ☐ multiple sclerosis ☐ other

Skin:

☐ skin color changes ☐ skin eruptions ☐ eczema. ☐ psoriasis ☐ scar tissue ☐ hot or warm areas ☐ abnormal hair loss
☐ other

Constitutional:

☐ fatigue ☐ fever ☐ weight gain ☐ weight loss ☐ allergies ☐ cancer ☐ depression ☐ diabetes ☐ epilepsy ☐ hepatitis
☐ nervousness ☐ asthma ☐ emphysema ☐ ulcers ☐ stomach pain ☐ painful urination ☐ prostate trouble ☐ Parkinson's
☐ other

Female:

☐ lumps in breast ☐ hot flashes ☐ irregular cycles ☐ menstrual cramps ☐ other
☐ are you pregnant? ☐ yes ☐ no ☐ maybe

Cardiovascular:

☐ chest pain ☐ leg cramps ☐ cold extremities ☐ cough ☐ congestive heart failure ☐ difficult breathing ☐ heart attack
☐ hypertension ☐ orthostatic hypotension ☐ phlebitis ☐ heart rhythm disturbance ☐ high cholesterol levels ☐ other

Hematological:

☐ anemia ☐ bleeding ☐ varicose veins ☐ other

Piercings: ☐ Ear? How many:_____ ☐ Body? Location(s):_____

Dental: ☐ Amalgam fillings? Location(s):_____

☐ Other dental problems (gingivitis, root canals, crowns, etc.)? Describe:_____
_____

Other diagnosed conditions:_____
_____

Have you ever had chiropractic care? ☐ yes ☐ no Date: _____

Name of regular medical physician: _____

Date of last: spinal exam:_____spinal x-ray:_____chest x-ray:_____blood test:_____

PATIENT'S SIGNATURE: _____DATE:_____

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