FIRST *family chiropractic* WELLNESS

PATIENT *health* QUESTIONNAIRE

Name_____ Date _____

If you have ever had a listed symptom in the past, please check that symptom in the PAST column. If you are PRESENTLY having a particular symptom, check that symptom in the PRESENT column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

Past	Present	Condition	Past	Present	Condition
☐	☐	Abdominal Pain	☐	☐	Loss of Bladder Control
☐	☐	Abnormal Weight Gain/Loss	☐	☐	Low Back Pain
☐	☐	Angina	☐	☐	Mid Back Pain
☐	☐	Anorexia	☐	☐	Muscular In-coordination
☐	☐	Aortic Aneurysm	☐	☐	Neck Pain
☐	☐	Arthritis	☐	☐	Pain in Ankle or Foot
☐	☐	Asthma	☐	☐	Pain in Lower Leg or Knee
☐	☐	Bladder Infection	☐	☐	Pain in Upper Arm or Elbow
☐	☐	Blood Disorder	☐	☐	Pain in Upper Leg or Hip
☐	☐	Breast Soreness Lumps	☐	☐	Painful Urination
☐	☐	Cancer, Explain_____	☐	☐	PMS
☐	☐	Chest Pains	☐	☐	Profuse Menstrual Flow
☐	☐	Chronic Cough	☐	☐	Prostate Problems
☐	☐	Chronic Sinusitis	☐	☐	Rapid Heart Beat
☐	☐	Colitis	☐	☐	Rheumatoid Arthritis
☐	☐	Constipation/irregular bowel habits	☐	☐	Scoliosis
☐	☐	Convulsions	☐	☐	Shoulder Pain
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Depression	☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Dermatitis/Eczema/Rash	☐	☐	Tinnitus (Ear Noises)

Past	Present	Condition	Past	Present	Condition
☐	☐	Difficulty in Swallowing	☐	☐	Tumor, Explain_____
☐	☐	Dizziness	☐	☐	Ulcer
☐	☐	Emphysema (chronic lung disorders)	☐	☐	Visual Disturbances
☐	☐	Endometriosis	☐	☐	Wrist Pain
☐	☐	Epilepsy	☐	☐	Frequent Urination
☐	☐	Excessive Thirst	☐	☐	General Fatigue
☐	☐	Fainting	☐	☐	Hand Pain (R____L____)
☐	☐	Headache	☐	☐	Heart Attack
☐	☐	Heartburn/Indigestion	☐	☐	Hepatitis
☐	☐	High Blood Pressure	☐	☐	Irregular Menstrual Flow
☐	☐	Irritable Colon	☐	☐	Jaw Pain
☐	☐	Kidney Disorders (by condition)	☐	☐	Kidney Stones
☐	☐	Liver/Gallbladder problems	☐	☐	Loss of Appetite
☐	☐	Other _____			

Have You or Your Family Had:

Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Heart Problems
☐	☐	Rheumatoid Arthritis	☐	☐	Chronic Headaches
☐	☐	Epilepsy	☐	☐	Lung Problems
☐	☐	Diabetes	☐	☐	High Blood Pressure
☐	☐	Chronic Back Problems	☐	☐	Lupus

Present Weight _____Pounds Height _____ Feet _____ Inches

Do you have a permanent disability rating? Yes ☐ No ☐

Location_____

Date rating was received? _____ Rating Percentage_____

Please check any of the following that apply to you:

Past	Present	
☐	☐	Tobacco _____packs/day
☐	☐	Alcohol _____drinks/day/week/month
☐	☐	Pregnancy, #births_____
☐	☐	Birth control pills, Type _____
☐	☐	Alcohol Dependence Coffee/Tea/Caffeinated Soft drinks _____cups/cans per day

Medication (list of not listed elsewhere): _____

_____

Hospitalizations/Surgical Procedures (List if not described elsewhere): _____

_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition.

Print Name _____

Signature _____ **Date** _____