

# CHIROPRACTIC HEALTH QUESTIONNAIRE

**Please circle area of pain or malfunction on diagram**

**Are you now or have you suffered from any of the following. Check appropriate box.**

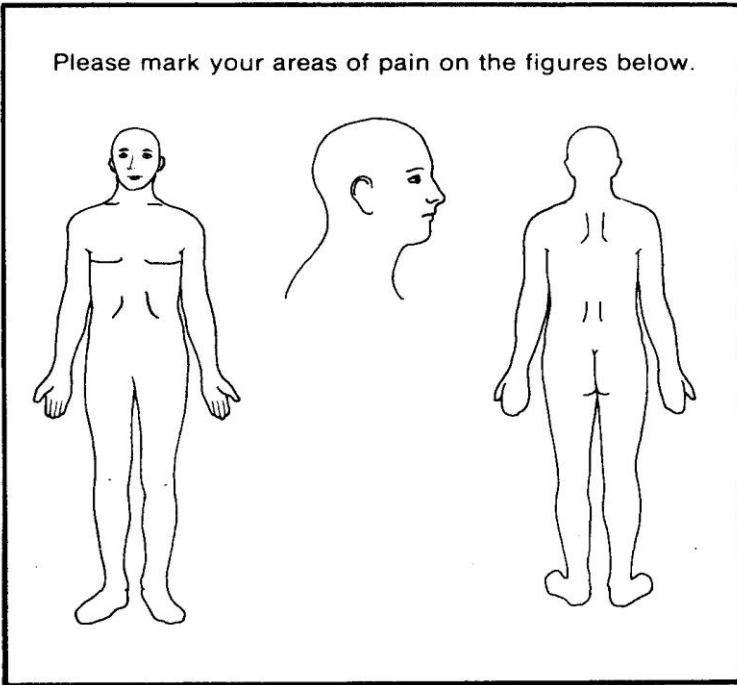
	Past	Present	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Taste
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Sleeping
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Smell
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Sore Throats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Digestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems

## Symptoms related to the Autonomic Nervous System

Chiropractic deals with the relationship between your spine and nervous system

The Nervous System's function is to control and co-ordinate all the other organs and structures. Pinched or irritated nerves may interfere with this function and thus cause a wide variety of symptoms.

Please mark your areas of pain on the figures below.



# THE SPINAL NERVE NETWORK

*Your nerves are a news network, transmitting messages and sensations from the brain to all parts of the body. Spinal pressure can cause a variety of ailments. Chiropractic can relieve many disorders by spinal adjustment, releasing pressure to permit normal nerve activity.*

## Normal motion should be full range and pain free.

If you have noticed any faults with the function of joints listed below - pain, stiffness, or noise, please check the appropriate squares and circle the area of pain on the drawing.

Pain	<input type="checkbox"/>			<input type="checkbox"/>	Pain
Stiff	<input type="checkbox"/>			<input type="checkbox"/>	Stiff
Noise	<input type="checkbox"/>			<input type="checkbox"/>	Noise
		LEFT	RIGHT		
		SIDE BENDING			

Pain	<input type="checkbox"/>			<input type="checkbox"/>	Pain
Stiff	<input type="checkbox"/>			<input type="checkbox"/>	Stiff
		LEFT	RIGHT		
		ROTATION			

Pain	<input type="checkbox"/>			<input type="checkbox"/>	Pain
Stiff	<input type="checkbox"/>			<input type="checkbox"/>	Stiff
Noise	<input type="checkbox"/>			<input type="checkbox"/>	Noise
		FORWARD	BACK		
		(FLEXION)	(EXTENSION)		

Pain	<input type="checkbox"/>			<input type="checkbox"/>	Pain
Stiff	<input type="checkbox"/>			<input type="checkbox"/>	Stiff
		LEFT	RIGHT		
		LATERAL BENDING			

Pain	<input type="checkbox"/>			<input type="checkbox"/>	Pain
Stiff	<input type="checkbox"/>			<input type="checkbox"/>	Stiff
Noise	<input type="checkbox"/>			<input type="checkbox"/>	Noise
		LEFT	RIGHT		
		ROTATION			

Pain	<input type="checkbox"/>			<input type="checkbox"/>	Pain
Stiff	<input type="checkbox"/>			<input type="checkbox"/>	Stiff
Noise	<input type="checkbox"/>			<input type="checkbox"/>	Noise
		BEND BACK	BEND FORWARD		

# Symptoms that can be related to Spinal Nerves

Past  
 Present  
 No

Scalp Disorders

Name: \_\_\_\_\_

Head Pain or Headaches

Main complaint & its symptoms: \_\_\_\_\_

Neck Pain

When did you first notice this problem? \_\_\_\_\_

Shoulder Pain or Stiffness

How does this condition interfere with normal living or working? \_\_\_\_\_

Arm Pain/Tingling or Numbness

Tennis Elbow

Was your condition caused by:

Loss of Arm Power

Auto       On the Job Injury       Other

Tingling, Numbness, or Pain of Hand

Describe: \_\_\_\_\_

Loss of Grip

Have you had any previous treatment for this or similar conditions?  Yes  No      When? \_\_\_\_\_

Mid Back Pain

Treated for how long? \_\_\_\_\_

Mid Back Tension

Who treated you? \_\_\_\_\_

Pain in Ribs

Results? \_\_\_\_\_

Low Back Pain

Have you had previous chiropractic care?  Yes  No

Low Back Weakness

Who treated you? \_\_\_\_\_

Low Back Stiffness

List all previous accidents or injuries: \_\_\_\_\_

Hip Pain or Stiffness

List any major illnesses: \_\_\_\_\_

Buttock Pain

List any operations: \_\_\_\_\_

Leg Cramps

Are you currently under any doctor's care? (Who & why): \_\_\_\_\_

Tingling, Numbness, or Pain of Leg

Are you currently taking any medication?  Yes  No

Knee Trouble

For what: \_\_\_\_\_

Foot Trouble

Is there any possibility that you might be pregnant?

Tingling, Numbness, or Pain of Foot

Yes  No

Please enter date of the first day of your last menstrual period: (month & day) \_\_\_\_\_

## PATIENT INFORMATION

(Please print answers to all questions.)

Patient's Last Name		First Name		M.I.	Home Phone #
Street Address		Apt/Lot #	City	State	Zip Code
Mailing Address (if different from above)			City	State	Zip Code
Birth Date	Age	Sex	Marital Status	Social Security Number	
Mo Day Year	( )	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sep		
Employer		Occupation/Job Title			Work Phone #
Employer's Address			City	State	Zip Code
Nearest Relative or Friend Not at Same Address			Relationship	Home Phone #	
Nearest Relative or Friend's Address			City	State	Zip Code
Spouse's Name		Employer	City	State	Work Phone #
Medical Doctor			City	State	Phone Number
Referred to this office by			Your Email Address		

## RESPONSIBLE PARTY

Last Name		First Name		M.I.	Home Phone #
Street Address		City		State	Zip Code
Employer		Occupation/Job Title			Work Phone #

## MEDICAL INSURANCE INFORMATION

Patient is:  Subscriber  Spouse  Dependent

Insurance Company	Address	City/State/Zip	Phone Number
Policy Holder	ID#	Group Number	
Other Insurance	Address	City/State/Zip	Phone Number
Policy Holder	ID#	Group Number	
Worker's Compensation:	Date of Injury	Date Last Worked	Claim Number

*I certify that the above information is true and correct. I hereby authorize the release of any information required. I also authorize my benefit payments to be paid directly to this office. I am financially responsible for non-covered services.*

Date:

Signature of Person Responsible:

**I will pay by:**

Cash

Check

Bank Card