

**Chiropractic & Massage Health Questionnaire**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years Employed: \_\_\_\_\_ Hours worked/week \_\_\_\_\_

Social Security: \_\_\_\_\_ Marital Status: S M D W Partner: \_\_\_\_\_

Children: No Yes Name/s and Age/s: \_\_\_\_\_

Have you had previous chiropractic care? No Yes \_\_\_\_\_ Has your family had chiropractic care? No Yes

Rate your current health habits:	Nutrition	GOOD	FAIR	POOR	Do you drink?	Yes	No
(circle which applies)	Sleep Habits	GOOD	FAIR	POOR	Do you smoke?	Yes	No
	Exercise	GOOD	FAIR	POOR	Drink coffee?	Yes	No
	Stress	GOOD	FAIR	POOR	Take Drugs?	Yes	No

Rate your current health: GREAT GOOD OKAY POOR Your Family's: GREAT GOOD OKAY POOR (circle which applies)

Do you presently have any health problems or major complaints?  No  Yes Explain: \_\_\_\_\_

How long have you had this? \_\_\_\_\_ It interferes with  work  home  family  sleep  sex  sports

What makes it worse? \_\_\_\_\_ Better? \_\_\_\_\_

Previous care for this condition?  No  Yes Explain \_\_\_\_\_

Is this condition getting better or worse?  No  Yes Explain \_\_\_\_\_

At its worst, how does it feel? \_\_\_\_\_ Do you want to get rid of this condition?  No  Yes

**CHECK ANY OF THE MUSCULO/SKELETAL SYSTEM THAT APPLIES:**

- |  |  |  |   |   |                                     |
|--|--|--|---|---|-------------------------------------|
| <input type="checkbox"/> Neck Pain     | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Arm Pain      | <input type="checkbox"/> Upper Back Pain  | <input type="checkbox"/> Mid Back Pain        | <input type="checkbox"/> Headaches  |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hip Pain      | <input type="checkbox"/> Leg Pain      | <input type="checkbox"/> Jaw Clicking     | <input type="checkbox"/> Walking Difficulty   | <input type="checkbox"/> Jaw Pain   |
| <input type="checkbox"/> Tingling      | <input type="checkbox"/> Burning Pain  | <input type="checkbox"/> Numbness      | <input type="checkbox"/> Dull Aches       | <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Fracture      | <input type="checkbox"/> Spinal Fusion | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Bone Deformities | <input type="checkbox"/> Dislocations         | <input type="checkbox"/> Arthritis  |

**CHECK ANY OF THE FOLLOING DISEASES OR ORGAN PROBLEMS YOU HAVE HAD:**

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Bladder Trouble     | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Excessive Urination   | <input type="checkbox"/> Discolored urine     | <input type="checkbox"/> Kidney Stones       |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Difficult Breathing |
| <input type="checkbox"/> Varicose Veins      | <input type="checkbox"/> Ankle Swelling    | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Bloating/Gas         | <input type="checkbox"/> Nausea/vomiting     |
| <input type="checkbox"/> Prostate Problems   | <input type="checkbox"/> Impotence         | <input type="checkbox"/> Menstrual Pain/cramps | <input type="checkbox"/> Menopause            | <input type="checkbox"/> Pregnancy           |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Stroke            | <input type="checkbox"/> TB                    | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Mental Disorder      | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> Thyroid             | <input type="checkbox"/> Eczema            | <input type="checkbox"/> Aids                  | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Paralysis           | <input type="checkbox"/> Hemorrhoids       | <input type="checkbox"/> Gall Stones           | <input type="checkbox"/> Prostate             | <input type="checkbox"/> Allergy             |

List all medications: \_\_\_\_\_

Prior accidents?  No  Yes (list) \_\_\_\_\_

Prior surgeries?  No  Yes (list) \_\_\_\_\_

**(CONTINUED ON OTHER SIDE)**