OPTIMAL CHIROPRACTIC

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CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete this form as accurately as possible. Your answers will help us determine whether chiropractic can help you. If we do not sincerely believe your condition can respond satisfactorily, we will not accept the case. Thank you for your cooperation.

Name: ____ Age: __________ Birth date: ______________________

Address: _____________________________________ City: ___________________ State: _____ Zip: ______________

Telephone #: (____) ______________ Alternate #: (____) _______________ Social Security #: ______-______-______

(Please Circle) Male or Female **Marital Status:** M S W D **Spouse's Name:** ______________________________

Do you have any children? ☐ Yes ☐ No If yes, how many? _______ How did you hear about us? _________________

What name would you like to be called in our office? ____

Your Occupation: __________________________________ Employer: ____

Emergency Contact: ____________________________ Phone: ______________________ Relationship: ___________

Who is responsible for payment of the bill? ____

Physical activity at work: ☐No Manual Labor ☐Light Manual Labor ☐Moderate Manual Labor ☐Heavy Manual Labor

How would you grade your general stress level? ☐No Stress ☐ Minimal Stress ☐Moderate Stress ☐ Greatly Stressed

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Current Problems

What kinds of problems are you having today? ____

____

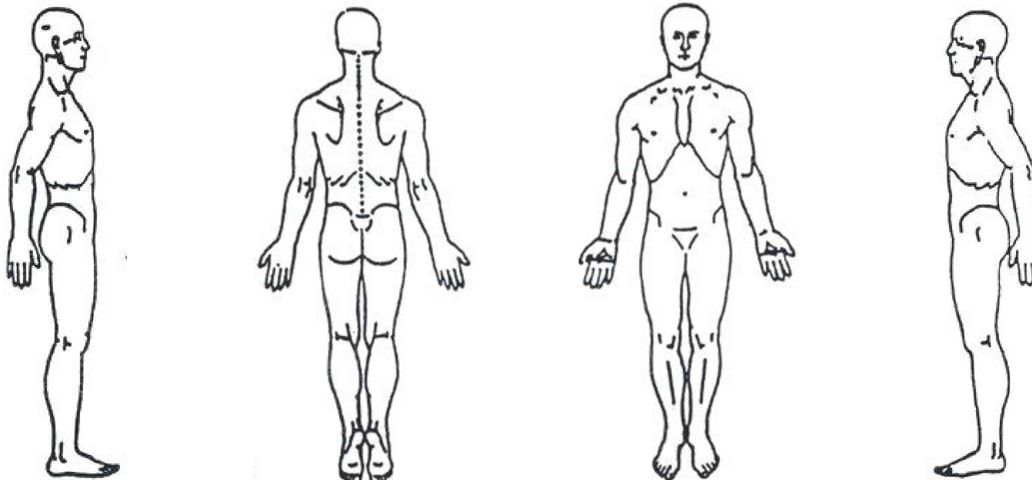
When did this problem begin? (Specific date if possible): ____

Do you know how your problem began? ____

____

Please describe your current pain (Check all that apply): ☐Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐Dull ☐Soreness ☐Weakness ☐Throbbing/Gnawing ☐Numbness ☐Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

PLEASE MARK AN "X" ON THE BODY BELOW WHERE YOU HAVE PAIN OR DISCOMFORT, INCLUDING NUMBNESS OR TINGLING



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Are your complaints affecting your ability to work or otherwise be active? ☐ Yes ☐ No

If yes, please check the one you are closest to:

☐ Need limited assistance with everyday tasks ☐ Have a significant inability to function without assistance

☐ Some physical restrictions (need assistance often) ☐ Totally disabled (impaired). Cannot care for self.

Have you consulted other doctors for these symptoms? ☐ Yes ☐ No

If yes, please list the name, date(s) seen, and type of treatment: ____

____

Is this the first time you've had these symptoms? ☐ Yes ☐ No

If no, were you previously treated for these symptoms? ☐ Yes ☐ No

If yes, please specify dates and type of treatment: ____

____

Past Medical History

Name and Address of Medical Doctor: ____

____ Doctor Phone #: (_____) ____________________

Date of last: Physical Exam: _____________ Blood Pressure Check ______________ X-Rays______________

List any current medications: ____

____

Are there any illnesses in your family? ☐ Yes ☐ No If yes, please specify: __________________________________

____

Any prior auto, work, or other accidents? ☐ Yes ☐ No If yes, please give dates and details: _______________

____

General physical activity: ☐ No Regular Exercise ☐ Light Regular Exercise ☐ Strenuous Exercise

Please check the appropriate box if any of the following apply to you (past or present)

GENERAL	Severe	Mod	Mild
Allergy			
Dizziness			
Ear Problems			
Fatigue			
Colds/Sinus Infections			
Headaches			
Nervousness			
Nose Bleeds			
Numbness			
Sore Throat			
Sudden Weight Loss/Gain			
Tonsillitis			

GENITO-URINARY	Severe	Mod	Mild
Frequest Urination			
Inability to Control Urine			
Kidney Infection or Stones			
Painful Urination			
Prostate Trouble			

CARDIO-VASCULAR	Severe	Mod	Mild
High Blood Pressure			
Heart Condition			
Swelling of Ankles			

GASTROINTESTINAL	Severe	Mod	Mild
Constipation			
Diarrhea			
Gall Bladder Trouble			
Intestinal Trouble			
Nausea/Vomiting			
Stomach Problems			

RESPIRATORY	Severe	Mod	Mild
Chest Pain			
Chronic Cough			
Difficulty Breathing			

MUSCLE & JOINT	Severe	Mod	Mild
Ankle Pain			
Arm/Shoulder Pain			
Elbow Pain			
Foot Trouble/Pain			
Knee Pain			
Leg Pain			
Neck Pain			
Pain between Shoulders			
Lower Back Pain			
Rib Pain			
Swollen Joints			

DO YOU HAVE	Yes	No
AIDS		
Alcoholism		
Anemia		
Arthritis		
Asthma		
Cancer		
Diabetes		
Heart Disease		
Mental Disorders		
Nervous Breakdown		
Polio		
Rheumatic Fever		

FOR WOMEN ONLY	Yes	No
Hot Flashes		
Irregular Cycle		
Lumps in Breast		
Painful Menstration		

HABITS

Coffee/Tea_____Cups/Day

Tobacco _____Pack(s)/______

Alcohol _____Drink(s)/______

Sleep ______Hrs./Night