

HEALTH QUESTIONNAIRE

No information contained in this form is released to anyone without your written approval.

Patient Name: _____ Age: _____

Reason for this visit: _____

When did your symptoms first appear? _____ Is it getting worse? Yes No

Do the symptoms come and go or are they constant? Constant Comes and goes

On a scale from 0-10 (0=No Pain 10=Severe Pain) how would you rate your pain? _____

Activities or movements that are painful to perform: Walking Sitting Bending Standing Other

Do your symptoms interfere with: Work Sleep Daily Routine Recreation

Are your symptoms caused by trauma (i.e. slip or fall, fall from horse, auto or vehicle accident, hitting an object or an object hitting you)?

Have you ever had this problem before? Yes No If yes when? _____

If yes, what kind of care did you receive? _____ Did it help? Yes No

Have you ever been to a Chiropractor, if so when and who? _____

Did your Chiropractor take x-rays of your spine? Yes No Were you informed of any abnormalities or reasons you should not have chiropractic care? Yes No

Do you use tobacco products? Yes No If yes, what kind, how often and how much? _____

Do you drink alcohol? Yes No If yes, what kind, how often and how much? _____

What is (if retired What was) your occupation? _____

How long have/had you been in this occupation? _____

Have you ever been involved in a motor vehicle accident, **even a minor fender bender**? Yes No

If yes, when? _____

Circle all that apply. Have you ever had:

List Medications you

Anemia	Arthritis	Asthma	Bronchitis	<u>Currently take</u>
Bleeding Disorders	Bruise Easily	Breast Lump	Cancer	_____
Diabetes	Dental Problems	Depression	Difficulty Sleeping	_____
Dizziness	Fainting	Numbness	Tiredness	_____
Fractures	Gout	Heart Disease	Hepatitis	_____
Hernia	Herpes/Cold Sores	High Cholesterol	High/Low Blood Pressure	_____
HIV +	Kidney Disease	Liver Disease	Migraine Headaches	_____
Miscarriage	Multiple Sclerosis	Osteoporosis	Pacemaker	_____
Pregnancies	Polio	Prostate Problems	Rheumatic Fever	_____
Scarlet Fever	Stroke	Tuberculosis	Tumors or Growths	_____
Ulcers	Vaginal Infections	Yeast Infections	Whooping Cough	_____
Weight Loss/Gain	Blood in Urine	Painful Urination	Lack of Bladder Control	_____
Bowel Changes	Constipation	Diarrhea	Excessive Thirst	_____
Excessive Gas	Indigestion/Heartburn	Rectal Bleeding	Pneumonia	_____
Vomiting Blood	Irregular Heartbeat	Swelling in Ankles	Varicose Veins	_____
Blurred Vision	Double Vision	Earaches	Nosebleeds	_____
Persistent Cough	Ringling in Ears	Sinus Problems	Erectile Dysfunction	_____

Have you ever had any surgeries, medical problems or conditions not listed above? If yes, please list.

I certify that the above information is correct to the best of my knowledge. I will not hold Country Chiropractic & Wellness Center, PA, Dr. D'Amada or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____