HealthSource Chiropractic

Patient Questionaire

Patient Name: _____ Date: _____

Please list other doctors or therapists you have seen for this condition:

Name **When were you treated?** **Type of treatment/therapies?**

How did the injury occur?

Did you require hospitalization?

Have you had a recent major surgery or illness? Yes or No (circle one)
If yes, please describe:

Have you lost any days from work? Yes or No (circle one)
If yes, please describe:

Are you taking prescription, over-the-counter, or birth control medication? Yes/No
List medications:

Do you smoke? Yes/no (circle one) If yes, _____packs/day for _____Years.

Circle the following conditions that you or your blood relatives have had:

Back/neck problems	Cancer	Heart Attack
Stroke	Arthritis	Diabetes
High blood pressure	Osteoporosis	Drug/alcohol abuse

Are you pregnant? Yes or No (circle one)

Check symptoms you have noticed since the injury/accident/pain syndrome:

_____Headache	_____Numbness in Fingers	_____Cold Sweats
_____Neck Pain	_____Numbness in Toes	_____Pins/Needles in Legs
_____Neck stiffness	_____Depression	_____Hands Cold
_____Constipation	_____Pins/Needles in Arms	_____Ears Ring/Buzz
_____Back Pain	_____Loss of Memory	_____Feet Cold
_____Nervousness	_____Head seems too heavy	_____Stomach Upset
_____Tension	_____Loss of Balance	_____Dizziness
_____Fainting	_____Diarrhea	_____Sleeping Problems