

\*You are able to fill this form out on your computer before printing, if you wish.

Date / /

HEALTH QUESTIONNAIRE

File#

First Name MI Last SS# - -

Mailing Address City State Zip

Physical Address City State Zip

Hm# Wk# Mobile E-Mail

Northern Address City State Zip
At Northern address from: / / to / / Phone: - -

Date of Birth / / Age Sex: Female Male DL#

Marital Status: M S D W #of children How did you hear about us? Yellow pgs Radio News Publication Ins. Company Friend/Other

Spouse's Name Employer/School

Address City State Zip

IN CASE OF EMERGENCY, CONTACT
Name Relationship to Patient Phone #:
Address City State Zip

Will we be filing insurance for you? No Health Medicare Medicaid Auto Accident Date Time Supervisor
Additional accident paperwork must be completed

Name of Insurance Co. Policy#

Policy Holder Relationship to Patient

PEOPLE AUTHORIZED TO ACCESS YOUR ACCOUNT:

Name Relationship to patient Allowed access to:
Scheduling Billing Health Information

Patient Signature Date / /

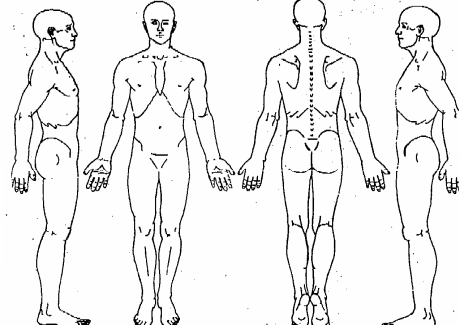
**CURRENT PROBLEM:** What pain are you feeling today? List your most painful symptoms first.

Problem	which travels to:	worse when:	better when:	pain level (10=Emergency)	timing
sample Neck Pain	Right Arm	Reaching	Sleeping	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Constant <input type="checkbox"/> On/Off
①				① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ <input type="checkbox"/>	<input type="checkbox"/> Constant <input type="checkbox"/> On/Off
②				① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ <input type="checkbox"/>	<input type="checkbox"/> Constant <input type="checkbox"/> On/Off
③				① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ <input type="checkbox"/>	<input type="checkbox"/> Constant <input type="checkbox"/> On/Off

When did your pain start? Mark the areas of your pain →

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Or  Hours  Days  Weeks  Years ago.

Details: \_\_\_\_\_  
\_\_\_\_\_



*Office Use*  
Height: \_\_\_\_\_  
Weight: \_\_\_\_\_  
BP: R/L \_\_\_\_/\_\_\_\_  
Pulse: \_\_\_\_\_  
Temp: \_\_\_\_\_

Have you had this current problem before?  No  Yes Details: \_\_\_\_\_

**PAST HISTORY:**  NONE Have you been injured in the past? List the most recent injury first.

①	/ /	<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Sports <input type="checkbox"/> Fall <input type="checkbox"/> Other	Details: _____
②	/ /	<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Sports <input type="checkbox"/> Fall <input type="checkbox"/> Other	Details: _____
③	/ /	<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Sports <input type="checkbox"/> Fall <input type="checkbox"/> Other	Details: _____

**MEDICAL HISTORY:**  NONE

- High Blood Pressure  Heart Trouble  HIV  Diabetes  Previous Back Problems  
 Kidney Problems  Currently Pregnant  Cancer  Stroke/Carotid Artery Disease  Surgeries, list with dates below:

\_\_\_\_\_

Medications: \_\_\_\_\_

Doctor	Name	Last Visit	Results related to current condition
Primary MD	_____	/ /	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> None <input type="checkbox"/> Worse <input type="checkbox"/> N/A
Specialist	_____	/ /	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> None <input type="checkbox"/> Worse <input type="checkbox"/> N/A
Chiropractic	_____	/ /	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> None <input type="checkbox"/> Worse <input type="checkbox"/> N/A

**SOCIAL HISTORY:**

- ① Smoker:  No  Yes \_\_\_\_\_ packs/\_\_\_\_day\_\_\_\_week  
 ② Alcohol:  No  Yes \_\_\_\_\_ drinks/\_\_\_\_day\_\_\_\_week or  only on occasion  
 ③ Work: \_\_\_\_\_ years  Full-Time  Part-Time  Retired  Disabled  
 Past or Current Type of Work: \_\_\_\_\_  
 ④ Activities:  Golf  Tennis  Running  Biking  Other \_\_\_\_\_

**ALLERGIES:**  NONE

- Seasonal  Mold  Pollen  Dust  Animals  Drugs  Other \_\_\_\_\_

**FAMILY HISTORY:**  NONE

Condition:	Heart Disease	Blood Pressure	Cancer	Diabetes	Stroke	Other
Mother's Side:	<input type="checkbox"/>	<input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father's Side:	<input type="checkbox"/>	<input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Siblings:	<input type="checkbox"/>	<input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_