

CHIROPRACTIC HEALTH QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status: M W D S Engaged Spouse's/Fiancé's name \_\_\_\_\_

No. of Children \_\_\_\_\_

1. Most patients are referred to our office from a caring family member or friend. What made you decide to visit our office?  Friend or Family Member Name: \_\_\_\_\_  Drove by our office  Magazine  Presentation  Health Fair  Insurance Co.  Email  Other \_\_\_\_\_

2. How many times have you visited a Doctor of Chiropractic in your lifetime, where and when? \_\_\_\_\_  I was receiving monthly wellness chiropractic care.  I never visited a chiropractor before today.

3. Stress and Physical trauma can cause and accelerate spinal damage. Have you ever been in a car accident?  no  yes- when & how: \_\_\_\_\_ Have you ever been injured at work?  no  yes- when & how: \_\_\_\_\_ Have you ever had a fall or sports injury  no  yes- when & how: \_\_\_\_\_ Have you ever had non-car-related accidents (even minor)?  no  yes- when & how: \_\_\_\_\_ Do you, or have you ever, work at a desk or a computer?  yes  no Do you, or have you ever, have to perform repeated lifting?  yes  no

4. The normal jolts, twists and impacts from sports can cause damage to the spinal column and nervous system. Which sports have you participated in? Past: \_\_\_\_\_ Present: \_\_\_\_\_

5. What medications are you currently taking and what are they for? \_\_\_\_\_

6. Spinal health is especially important during pregnancy. Is there any chance you are pregnant?  no  yes: weeks: \_\_\_\_\_

7. At our office we are not only interested in your health and wellbeing, but also the health and wellbeing of your family and loved ones. Please mention below any health conditions or concerns you may have about your: Children \_\_\_\_\_ Spouse \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Others \_\_\_\_\_

8. Please provide the date and location of your previous test(s): Date of x-rays: \_\_\_\_\_ Where they were taken: \_\_\_\_\_  None Date of MRI: \_\_\_\_\_ Where it was taken: \_\_\_\_\_  None Date of CAT Scan: \_\_\_\_\_ Where it was taken: \_\_\_\_\_  None Date Other: \_\_\_\_\_ Where it was taken: \_\_\_\_\_  None

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9. Other healthcare professionals who you have seen for your present concern(s):

Doctor/Therapist: \_\_\_\_\_ When: \_\_\_\_\_ Diagnosis and Treatments: \_\_\_\_\_  
\_\_\_\_\_ Results: \_\_\_\_\_  
Doctor/Therapist: \_\_\_\_\_ When: \_\_\_\_\_ Diagnosis and Treatments: \_\_\_\_\_  
\_\_\_\_\_ Results: \_\_\_\_\_

10. Name of Primary Care Physician (PCP): \_\_\_\_\_

(We may send a report to your Primary Care Physician- if you would also like it sent to an additional doctor, please inform our office)

11. Do have any of the following conditions, receive or received in the past the following treatments:

- 1. Articular hyper mobility (over-flexible joints) and circumstances where the stability of your joints or a single joint is uncertain? No Yes: \_\_\_\_\_
- 2. Do you have any artificial joints? No Yes: \_\_\_\_\_
- 3. Severe demineralization of bone (such as osteoporosis or osteopenia)? No Yes: \_\_\_\_\_
- 4. Are you presently or have you in the past been on steroid medications? No Yes: \_\_\_\_\_
- 5. Benign bone tumors (spine)? No Yes: \_\_\_\_\_
- 6. Bleeding disorders and/or anticoagulant therapy? No Yes: \_\_\_\_\_
- 7. Problems with the arteries in the neck such as hardening or calcifications? No Yes: \_\_\_\_\_
- 8. Radiculopathy (nerve problems in your arms or legs) with progressive neurological signs? No Yes: \_\_\_\_\_
- 9. Acute arthropathies (joint diseases) characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation; including acute rheumatoid arthritis and ankylosing spondylitis?  
No Yes: \_\_\_\_\_
- 10. Acute (recent) fractures and dislocations or healed fractures and dislocations with signs of instability?  
No Yes: \_\_\_\_\_
- 11. An unstable os odontoideum (abnormal gap in the bones of the upper neck)? No Yes: \_\_\_\_\_
- 12. Malignancies (cancers) that involve the vertebral column (spine)? No Yes: \_\_\_\_\_
- 13. Infection of bones or joints of the vertebral column (spine)? No Yes: \_\_\_\_\_
- 14. Do you have loss of control over your bladder or bowel functions? No Yes: \_\_\_\_\_
- 15. Do you get dizzy, nauseous, visual disturbances or blackout with certain head positions such as looking up and/or to the side or when getting your hair washed in a salon sink? No Yes: \_\_\_\_\_
- 16. Transient ischemic attacks or a stroke? No Yes: \_\_\_\_\_
- 17. An aneurysm (balloon-like bulge in the wall of a blood vessel)? No Yes: \_\_\_\_\_

12. Do you foresee any obstacles in your ability to improve the your level of health: No Yes: \_\_\_\_\_

13. What goals do you hope to achieve with the care in our office: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Legal Guardian Name (printed)

\_\_\_\_\_  
Legal Guardian Signature

\_\_\_\_\_  
Date

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_

Scott Rosenthal, DC