

HEALTH QUESTIONNAIRE Initial Re-Eval

Use a No. 2 pencil to mark your answers. When marking in an Other bubble please explain in the space allowed. Fill in bubbles completely as indicated here: Erase changes cleanly. Do not fold form.

Patient Name: _____

| MO | DAY | YEAR | DR# | PATIENT NUMBER | | | | | | | | | | | | | | | | | | | |
|----|-----|------|-----|----------------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 7 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2 | 8 | 2 | 10 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3 | 9 | 3 | 20 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| 4 | 10 | 4 | 30 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| 5 | 11 | 5 | 40 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| 6 | 12 | 6 | 50 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| | | 10 | 7 | 60 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| | | 20 | 8 | 70 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| | | 30 | 9 | 80 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |
| | | | | 90 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |

A. PATIENT INFORMATION

Marital Status: Single Married Separated Divorced Widowed

Sex: M F

Children: 0 1 2 3 4 5+

Patient Lives With: Alone Spouse Children Other Parents Roommate(s) Assisted Living

B. PATIENT'S COMPLAINTS 1. Mark Your Present Complaints Below Physical Examination with no complaints.

Neck / Back

| | | | Same As Left | | | | | | Mild | Moderate | Severe | Burning | Dull | Sharp | Shooting | Aching | Throbbing | Occasional | Intermittent | Frequent | Constant | Improving | Worsening | Unchanged | Resolved | | | |
|----------|-------|--|--------------|----------|----------|-----------|----------|----------|------|----------|--------|---------|------|-------|----------|--------|-----------|------------|--------------|----------|----------|-----------|-----------|-----------|----------|---|----------|--|
| | | | Pain | Numbness | Tingling | Stiffness | Soreness | Swelling | | | | | | | | | | | | | | | | | | | Weakness | |
| Neck | Left | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | When Did Your Neck/Back Complaints Begin? <input type="radio"/> Date: _____ / ____ / ____ |
| | Right | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| Upr Back | Left | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Right | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| Mid Back | Left | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Right | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| Low Back | Left | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Right | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| Ribs | Left | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Right | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |

Upper Extremities

| | | | Same As Above | | | | | | Mild | Moderate | Severe | Burning | Dull | Sharp | Shooting | Aching | Throbbing | Occasional | Intermittent | Frequent | Constant | Improving | Worsening | Unchanged | Resolved | | | |
|-------|----------|--|---------------|----------|----------|-----------|----------|----------|------|----------|--------|---------|------|-------|----------|--------|-----------|------------|--------------|----------|----------|-----------|-----------|-----------|----------|---|----------|--|
| | | | Pain | Numbness | Tingling | Stiffness | Soreness | Swelling | | | | | | | | | | | | | | | | | | | Weakness | |
| LEFT | Shoulder | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | When Did Your Upper Extremity Complaints Begin? <input type="radio"/> Same Date As Neck/Back <input type="radio"/> Different Date: _____ / ____ / ____ |
| | Arm | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Elbow | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Forearm | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Wrist | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Hnd/Fgrs | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| RIGHT | Shoulder | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Arm | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Elbow | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Forearm | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Wrist | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Hnd/Fgrs | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |

Lower Extremities

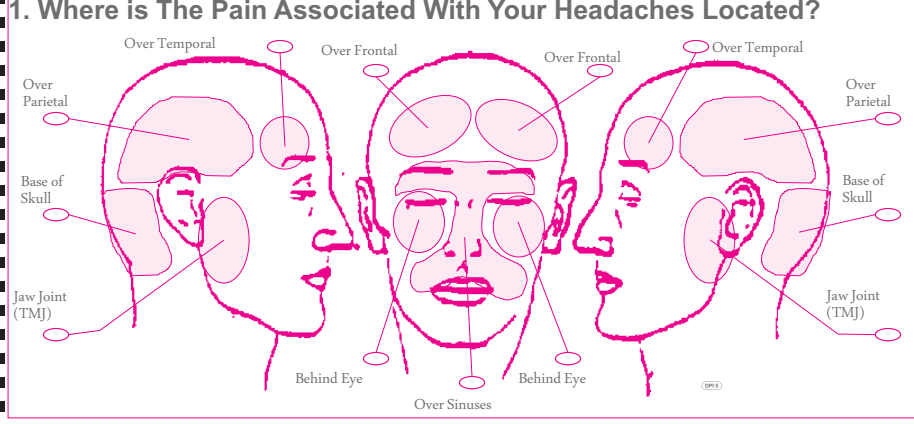
| | | | Same As Above | | | | | | Mild | Moderate | Severe | Burning | Dull | Sharp | Shooting | Aching | Throbbing | Occasional | Intermittent | Frequent | Constant | Improving | Worsening | Unchanged | Resolved | | | |
|-------|----------|--|---------------|----------|----------|-----------|----------|----------|------|----------|--------|---------|------|-------|----------|--------|-----------|------------|--------------|----------|----------|-----------|-----------|-----------|----------|---|----------|--|
| | | | Pain | Numbness | Tingling | Stiffness | Soreness | Swelling | | | | | | | | | | | | | | | | | | | Weakness | |
| LEFT | Hip | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | When Did Your Lower Extremity Complaints Begin? <input type="radio"/> Same Date As Neck/Back <input type="radio"/> Different Date: _____ / ____ / ____ |
| | Buttock | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Thigh | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Knee | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Leg/Calf | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Ankle | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| RIGHT | Hip | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Buttock | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Thigh | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Knee | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Leg/Calf | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |
| | Ankle | | S | P | N | T | S | S | S | W | M | M | S | B | D | S | S | A | T | O | O | F | C | I | W | U | R | |

- 2. How Did Your Complaint(s) Begin[1]?**
 Unknown Suddenly Gradually
- 3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?**
 Cause Not Known Auto Accident
 Work Accident/Injury Home Accident
 Personal Injury Sport Injury
- Other - Describe: _____
- 4. How Would You Rate Your Overall Pain Today Where 0 Is No Pain And 10 Is The Worst Pain[1]?**
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible
- 5. When Are Your Symptoms Worse?**
 Morning Afternoon Evening Night
 Always The Same
- 6. What Makes Your Condition Better?**
 Nothing Stretching Heat
 Rest Exercise Ice
 Sitting Standing Medications
 Other

- 7. What Makes Your Condition Worse?**
 Nothing Coughing Reaching Standing
 Sneezing Lifting Sitting Pulling
 Bending Walking Straining at Stool Turning
 Other
- 8. Have Any Of Your Complaint(s) Existed In The Past? Yes No**
 If Yes, Indicate Below
 Neck Upr Back Mid Back Low Back Ribs
 Shoulder Arm Elbow Forearm Wrist Hnd/fgrs
 Buttock Hip Thigh Knee Leg/calf Ankle Foot
 Others: _____
- 9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office[1]?**
 Yes No If Yes, List Dates, Treatments, And Doctors.
- 10. Since Your Symptoms Began, Have You Noticed A Change In?**
- | | | | |
|------------------|---------------------------|--------------------------|---------------------------------|
| Bowel Function | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> No To All |
| Bladder Function | <input type="radio"/> Yes | <input type="radio"/> No | |
| Sexual Function | <input type="radio"/> Yes | <input type="radio"/> No | |

C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.



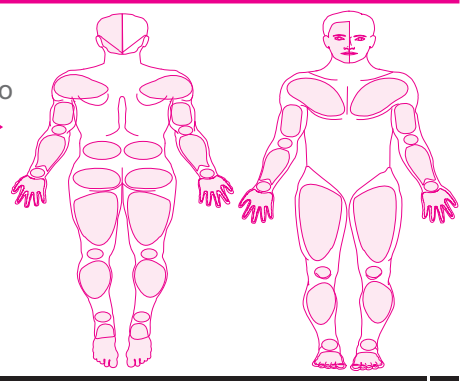
- 6. What Seems To Bring On Your Headaches?**
 Physical Activity Caffeine
 Excessive Stress Certain Foods
 Alcohol Menstrual Period
 Other
- 7. How Often Do They Occur[1]?**
 Times/Week: 1 2 3 4 5 6 7 8 9
 Times/Month: 1 2 3 4 5 6 7 8 9
 Other
- 8. How Long Do Your Headaches Last[1]?**
 Less Than 1 Hour From 1-3 Hours
 Longer Than 3 Hours All Waking Hours
 Several Hours To Days
 Other

- 2. On What Date Did Your Headaches Begin[1]?**
 Date: ___ / ___ / ___ Same As Neck/Back Complaints
- 3. How Does The Intensity Of Your Headaches Rate[1]?**
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible
- 4. What Describes Your Pain?**
 Dull Sharp Aching Stabbing
 Deep Vice-Like Burning Throbbing/Pulsating
 Other
- 5. When Do Your Headaches Usually Start?**
 Constant/Anytime Awake Wake Up With In Morning
 At Midday During Evening

- 9. Do Your Headaches Wake You From Sleep[1]?**
 No Sometimes Always
- 10. Do Any Of The Following Occur With Your Headaches?**
 Nausea/Vomiting Weakness
 Tremor Vision Problems
 Dizziness Light/Sound Sensitivity
 Other
- 11. What Makes Your Headaches Better?**
 Nothing NSAIDS (Aspirin, Tylenol, etc.) Rest
 Massage Lying Down Standing Ice/Cold Packs
 Other

D. OTHER COMPLAINTS

Do you have any other complaints not covered on this form[1]? Yes No
 If Yes, Describe other complaints in detail and mark body areas on Figures. →



HEALTH QUESTIONNAIRE-HISTORY F. HABITS/ACTIVITIES

Patient's Name

E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

| | |
|--|---|
| <input type="radio"/> None Of The Symptoms Listed Below | <input type="radio"/> No New Symptoms Since Your Last Exam |
|--|---|

| | |
|---|--|
| <input type="radio"/> General Fatigue | <input type="radio"/> Skin Rash |
| <input type="radio"/> Weakness | <input type="radio"/> Redness Of Skin |
| <input type="radio"/> Fever (continuous) | <input type="radio"/> Skin Itching |
| <input type="radio"/> Loss Of Sleep | <input type="radio"/> Skin Dryness |
| <input type="radio"/> Chills (continuous) | <input type="radio"/> Eczema(red, inflamed skin) |
| <input type="radio"/> Weight Change (unplanned) | <input type="radio"/> Hair Changes (unplanned) |
| <input type="radio"/> Night Sweats | <input type="radio"/> Nail Changes (unplanned) |

| | |
|---------------------------------|-------------------------------------|
| <input type="radio"/> Headaches | <input type="radio"/> Bruise Easily |
|---------------------------------|-------------------------------------|

| | |
|-----------------------------------|--|
| <input type="radio"/> Dizziness | <input type="radio"/> Cough (chronic) |
| <input type="radio"/> Fainting | <input type="radio"/> Wheezing (chronic) |
| <input type="radio"/> Convulsions | <input type="radio"/> Difficulty Breathing |
| <input type="radio"/> Nervousness | <input type="radio"/> Swollen Extremities |

| | |
|---|--|
| <input type="radio"/> Anxiety | <input type="radio"/> Blue Extremities |
| <input type="radio"/> Depression (prolonged) | <input type="radio"/> Varicosities (visible veins) |
| <input type="radio"/> Phobias (excessive fears) | <input type="radio"/> Rapid Heart Beat |
| <input type="radio"/> Memory Loss Or Impairment | <input type="radio"/> Chest Pain |
| <input type="radio"/> Mood Swings (excessive) | <input type="radio"/> Heart Palpitations |

| | | | |
|---------------------------------------|-----------------------|-----------------------|--|
| | Left | Right | <input type="radio"/> Heart Murmur |
| <input type="radio"/> Hearing Trouble | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Decreased Appetite |
| <input type="radio"/> Ringing in Ears | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Increased Appetite |
| <input type="radio"/> Pain in Ears | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Abdominal Pain |
| <input type="radio"/> Ear Discharge | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Hemorrhoids |

| | | | |
|--|-----------------------|-----------------------|--|
| <input type="radio"/> Vision Trouble | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Excess Gas |
| <input type="radio"/> Pain in Eyes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Vomiting (excessive) |
| <input type="radio"/> Eye Discharge | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Diarrhea (excessive) |
| <input type="radio"/> Nose/Sinus Pain | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Constipation (excessive) |
| <input type="radio"/> Excessive Drainage | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Heartburn/Indigestion |

| | |
|--|---|
| <input type="radio"/> Nose Bleeds (chronic) | <input type="radio"/> Painful Urination |
| <input type="radio"/> Nasal Infections (chronic) | <input type="radio"/> Inability To Hold Urine |
| <input type="radio"/> Absence Of Smell | <input type="radio"/> Frequent Urination |

| | |
|--|---|
| <input type="radio"/> Mouth Sores | <input type="radio"/> Urinary Retention |
| <input type="radio"/> Bleeding Gums | <input type="radio"/> Bed-wetting |
| <input type="radio"/> Enlarged Glands | <input type="radio"/> Irregular Menstruation |
| <input type="radio"/> Absence Of Taste | <input type="radio"/> Painful Menstruation |
| <input type="radio"/> Abnormal Taste Sensation | <input type="radio"/> Abnormal Vaginal Bleeding |
| <input type="radio"/> Tonsillitis/Infected Tonsils | <input type="radio"/> Sterility |
| <input type="radio"/> Difficulty With Swallowing | <input type="radio"/> Impotence |

| | |
|---|---|
| <input type="radio"/> Heat/Cold Intolerance | <input type="radio"/> Lumps In Breast(s) |
| <input type="radio"/> Sugar In Urine | <input type="radio"/> Redness/Itching of Breast |
| <input type="radio"/> Goiter (enlarged Thyroid gland) | <input type="radio"/> Dimpling of Breast(s) |
| <input type="radio"/> Tremor (shaking) | <input type="radio"/> Discharge from Breast(s) |
| | <input type="radio"/> Breast Pain |

Other (Please Describe)

What Are Your Habits?

Smoking..... Never None <1 1-2 2-3 3-4 5+

Caffeinated Drinks..... Never None <1 1-2 2-3 3-4 5+

Alcohol Consumption..... Never None <1 1-2 2-3 3-4 5+

Drug/Substance Abuse.. No Yes If Yes, Discuss With Doctor

Exercise..... Never <1 1-2 2-3 3-4 5+

Kinds Of Exercise You Do:

Walking Jogging Cycling Swimming

Golf Tennis Strength Training

Other: _____

G. MEDICAL HISTORY

1.HEALTH CARE

a. Have You Ever Been To A Chiropractor? Yes No

b. Do You Have A Family Physician Yes No

Date Of Last Physical Exam: _____

Physician's Name: _____

Address: _____

Phone:() _____

c. Have You Been Hospitalized In The Past? . . . Yes No

Date & Reason For Hospitalization: _____

d. Have You Ever Had Surgery? Yes No

Date, Reason, Results Of Surgery: _____

e. Have You Ever Had A Serious Accident/Injury? Yes No

List Date & Describe Injury: _____

Auto: _____

Work-Related: _____

Personal: _____

Sports Injury: _____

Other: _____

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements) Yes No

g. Are You Currently Taking Any Medications? Yes No

For What Condition(s) Are You Taking Medication?

Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.): _____

Pain/Analgesics: _____

Anti-Depressants: _____

Muscle Relaxants: _____

Blood Pressure Pills: _____

Antibiotics: _____

Birth Control Pills: _____

Corticosteroid: _____

Other: _____

In The Past Have You Use Any Of The Following?

Birth Control Pills Corticosteroid

h. Are You Allergic To Any Medications? Yes No

List Medications: _____

