

# NEW PATIENT HEALTH QUESTIONNAIRE

Date: \_\_\_\_\_  
 Full Name: \_\_\_\_\_ S.S.#: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have medical insurance? Yes No If yes, please give ALL cards to the secretary along with a photo ID  
 Is this your first visit to a chiropractor? Yes No If no, when was your last visit? \_\_\_\_\_  
 Are you pregnant? Yes No Due Date: \_\_\_\_\_  
 Please list any surgeries: \_\_\_\_\_  
 Have you had an X-ray MRI? Yes No  
 If yes, please list the facility name & phone number: \_\_\_\_\_  
 Do you have a Primary Care Physician? Yes No  
 Name, Address & phone number: \_\_\_\_\_  
 Briefly explain the reason for today's visit: \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_  
 On a pain scale of 1 – 10, 1 being almost no pain and 10 being the greatest, what do you rate your pain today? \_\_\_\_\_

**Please mark off your symptoms:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Shoulder pain – Lt / Rt | <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Ankle pain           |
| <input type="checkbox"/> Neck pain   | <input type="checkbox"/> Arm pain – Lt / Rt      | <input type="checkbox"/> Sciatica            | <input type="checkbox"/> Carpel Tunnel        |
| <input type="checkbox"/> Vertigo (Dizziness)   | <input type="checkbox"/> Mid-back pain           | <input type="checkbox"/> Hip pain            | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> TMJ ( Jaw pain)   | <input type="checkbox"/> Rib pain                | <input type="checkbox"/> Leg pain – Lt / Rt  | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Chronic Sinusitis   | <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Knee pain – Lt / Rt | <input type="checkbox"/> Osteoarthritis       |
| <input type="checkbox"/> Numbness / tingling in hands <input type="checkbox"/> Numbness / tingling in feet <input type="checkbox"/> Other: _____ |  |  |   |

<b><u>EXERCISE:</u></b>	<b><u>WORK ACTIVITY</u></b>	<b><u>HABITS</u></b>	
None	Sitting	Smoking	Pack/Day _____
Moderate	Standing	Alcohol	Drinks/Week _____
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day _____
Heavy	Heavy Labor	High Stress Level	Reason _____

**HEALTH HISTORY:**

**What treatment have you already received for your condition?**

Medications    Surgery    Physical Therapy    Chiropractic Services    None other: \_\_\_\_\_

**Name and address of other doctor(s) who have treated you for your condition** \_\_\_\_\_

**Please check off your medical history:**

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV             | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Asthma          |
| <input type="checkbox"/> Bleeding Disorders   | <input type="checkbox"/> Breast Lump      | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Cataracts       |
| <input type="checkbox"/> Chemical Dependency  | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Fractures       |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Gout                | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> Hernia               | <input type="checkbox"/> Herniated Disk   | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Liver Disease   |
| <input type="checkbox"/> Migraine Headaches   | <input type="checkbox"/> Miscarriage      | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Mumps           |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Pinched Nerve      | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Polio                | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Prosthesis          | <input type="checkbox"/> Psychiatric Care   | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tonsillitis         | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Whooping Cough   | <input type="checkbox"/> Other: _____        |   |  |

**MEDICATIONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VITAMINS/HERBS/MINERALS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient