Please check the appropriate box(es) for any of the following symptoms of ill health which you may now have or have had previously. In order to provide necessary chiropractic care we need to know all the facts related to your health. This is a Confidential Health Report.

- ☐ Headaches
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Pins + Needles in Arms
- ☐ Pins + Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Pain in the Arms
- ☐ Pain in the Legs
- ☐ Pain between Shoulders
- ☐ Hands Cold
- ☐ Feet Cold
- ☐ Neck Stiff
- ☐ Back Stiff
- ☐ Convulsions
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Eyes Sensitive to Light
- ☐ Loss of Memory
- ☐ Ringing in the Ears
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach Upset
- ☐ Poor Digestion
- ☐ Cold Sweats
- ☐ Loss of Balance
- ☐ Shortness of Breath
- ☐ Chronic Cough

Have you ever?

Yes	No	
☐	☐	Been Knocked Unconscious?
☐	☐	Used Crutches or other Support?
☐	☐	Been Treated for Spine Problems?
☐	☐	Been Treated for any Nerve Disorder?
☐	☐	Had a Fractured/Broken Bone?
☐	☐	Had Surgery?
☐	☐	Been Hospitalized for Other than Surgery?

Date of Last : (approximate)

- _____ Physical Examination
- _____ Blood Test
- _____ Urine Test
- _____ Chest X-ray
- _____ Spine X-ray
- _____ Dental X-ray
- _____ Other

Habits:

Have you in the past or do you currently use:

- ☐ Alcohol If yes how often? _____
- ☐ Coffee How many cups per day?_____
- ☐ Tobacco How many pack per day? _____

Is there a Family History of?

- ☐ Heart Disease ☐ Arthritis
- ☐ Cancer ☐ Diabetes
- ☐ Stroke ☐ _____

Your Current Problem

What are you current symptoms? 1. _____ 2. _____

3. _____ 4. _____

What level of intensity would you rate your pain? (10=severe) ***1 2 3 4 5 6 7 8 9 10***

What is the frequency of your symptoms? ***Occasional / Episodic / Intermittent / Frequent / Constant***

Do your symptoms affect your personal life? (hobbies, sports, etc) _____

_____

Do your symptoms affect your job / occupation?(missed days, inability to stand, sit, lift, drive) _____

_____

How long have you suffered from these symptoms? _____

Have you suffered from these symptoms before? ☐ Yes ☐ No

What makes your symptoms worse? _____

What makes your symptoms better? _____

What home remedies have you tried? _____

Have you been to any other type of doctor for this problem? _____

Have you been to a Chiropractor before? ☐ Yes ☐ No If Yes, Who?_____

After completing this questionnaire your signature will verify that all information you have given is to accurate to the best of your knowledge.

Signed: _____ Date: _____

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