Coast Chiropractic Centers Health History Questionnaire

Name: ________________________________ (**PLEASE MARK THE BOXES THAT BEST DESCRIBE YOUR CONDITION**)

HEADACHE PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Throbbing
Location = ☐ Right ☐ Left ☐ Face
☐ Forehead ☐ Back of head
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ________________________

NECK PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Throbbing
☐ Clicking/cracking ☐ Grinding/rubbing
Location = ☐ Right ☐ Left ☐ Face
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ________________________

MIDDLE BACK PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Throbbing
☐ Difficulty Breathing ☐ Chest Pain
Location = ☐ Right ☐ Left ☐ Central
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ____________________

LOWER BACK PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Burning
☐ Numbing ☐ Radiating into leg(s)
Location = ☐ Right ☐ Left ☐ Central
Location is ☐ Always the same ☐ ☐ can vary

How long have you had these symptoms? ____________________

SHOULDER/ARM/HAND PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Burning
☐ Numbness ☐ Coldness ☐ Weakness
Location = ☐ Right ☐ Left ☐ Both
☐ Shoulder ☐ Arm ☐ Hand
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ________________________

HIP/LEG/FOOT PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Burning
☐ Numbness ☐ Coldness ☐ Weakness
Location = ☐ Right ☐ Left ☐ Both
☐ Hip ☐ Leg ☐ Foot
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ________________________

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas.
Just to complete the picture, please draw in your face.

Numbness = = = = = = = = = Burning xxxxxxxxxxxx

Pins and needles oooooooooo Stabbing Pain / / / / / / /

Nagging/dull pain: : : : : : : Shooting pain ########

Radiation of Pain = ☐ Yes ☐ No
Aggravating Factors ☐ Sitting ☐ Standing
☐ Bending ☐ Reaching ☐ Other _____________
Alleviating Factors: ☐ Sitting ☐ Standing
☐ Laying ☐ Ice ☐ Heat
☐ Support ☐ Medication ☐ Other _____________

Associated Complaints: ___________________________________

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Comments: ____

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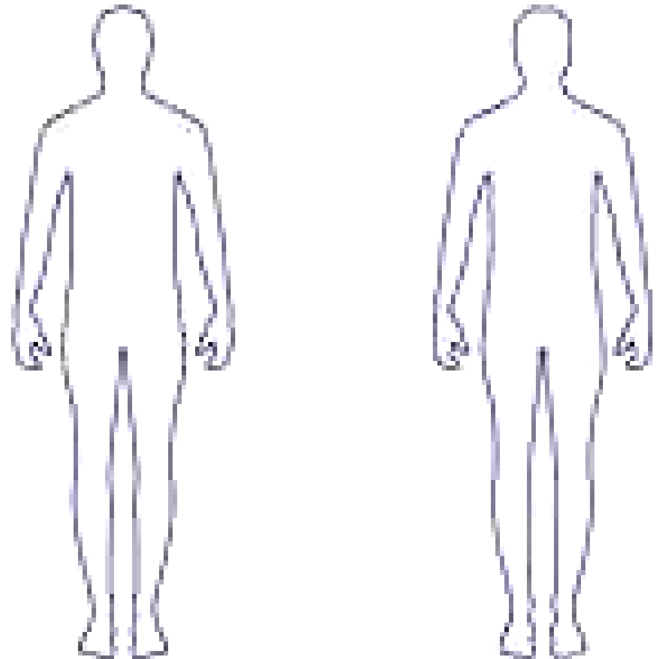

Front

Back

☐Yes ☐No Have you had previous chiropractic care? Dr. ___________________________

If yes, how long has it been since you've been treated: _______________?

☐Yes ☐No Were you hospitalized? Date admitted __/__/__ Date Discharged __/__/__

☐Yes ☐No Were you treated in another facility for this condition? Where ___________________________________

☐Yes ☐No Have x-rays been taken or was lab worked proposed and/or completed? When? ______________________

☐Yes ☐No Have you had any operations? Explain ______________________________________

List any drugs you are taking: ____

☐Yes ☐No Do you have morning stiffness which lasts more than 30 minutes?

☐Yes ☐No Are you interested in improving your general well being as well as dispensing with the symptoms that brought you to our office?

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, take time to answer these questions carefully as these problems can affect your overall diagnosis, treatment plan, and whether or not you are accepted for care.

☐Yes ☐No Have you ever had cancer?

☐Yes ☐No Are you losing weight without trying?

☐Yes ☐No Does your pain wake you up at night?

☐Yes ☐No Have you had a change in bladder or bowel habits?

☐Yes ☐No Have you had a sore that doesn't heal?

☐Yes ☐No Have you recently had any unusual bleeding or discharge?

☐Yes ☐No Do you have a thickening/ lump in breast anywhere?

☐Yes ☐No Are you having indigestion or difficulty swallowing?

☐Yes ☐No Do you have a nagging cough or hoarseness?

☐Yes ☐No Have you had an obvious change in a wart or mole?

Circle any of the following conditions you currently have or that tend to be recurrent problems. Check (√) those you have had in the past but are no longer a problem.

GENERAL	EENT	GASTRO-INTESTINAL	FEMALE	NERVOUS SYSTEM
Headaches	Eye problems	Poor appetite	Menstrual pain	Numbness
Allergies	Ear problems	Excessive Hunger	Menstrual irregularity	Paralysis
Hay fever	Nasal/sinus problems	Difficult swallowing	Vaginal pain	Dizziness
Hives	Throat trouble	Difficult chewing	Vaginal infection	Fainting
Fatigue	Loss of taste	Excessive thirst	Vaginal discharge	Confusion
Weight Loss	Loss of smell	Frequent nausea	Vaginal bleeding	Forgetfulness
		Vomiting	Breast pain/lumps	Depression
CARDIOVASCULAR/RESPIRATORY	GENITO-URINARY	Abdominal pain	Hot flashes	Convulsions
Chest pain	Pain/burning on urination	Diarrhea	Are you pregnant?	Muscle jerks
Difficult breathing	Difficulty starting to urinate	Constipation	☐ Yes ☐ No	Nervousness
Persistent cough	Inability to control urine	Black/bloody stool	Date of last period?	Neuralgia
Blood pressure problems	Frequent urination	Hemorrhoids	___/___/___	Insomnia
Asthma or bronchitis	Discolored urine	Indigestion		
Rapid or irreg. heartbeat	Bladder trouble	Gas of bloating		
Swollen ankles	Kidney infection or stones	Liver trouble		
Varicose veins	Sexual dysfunction	Gall bladder problems		
Hardening of arteries	Prostate troubles (male)	Colon trouble		
Legs hurt after walking				

IMPORTANT: DO YOU HAVE A PACEMAKER? ☐ **YES** ☐ **NO**

Circle any of the following diseases you have or had.

Appendicitis	Malaria	Chicken pox	Alcoholism	Typhoid fever	Goiter	Polio
Scarlet fever	Tuberculosis	Diabetes	Arthritis	Mental disorder	Lumbago	Influenza
Venereal disease	Cancer	Anemia	Heart disease	Rheumatic fever	Eczema	Small pox
Whooping cough	Epilepsy	Pneumonia	Measles	Diphtheria	Mumps	Pleurisy
AIDS						

Signature: ____ Date ____/____/_____

Comments: ____