Pedersen Chiropractic

God's Love, Our Hands, Your Health

File #_____

Date _____

Health Questionnaire

Patient Information

Date_____

Name_____

Last Name First Name Middle Initial

Sex ☐ M ☐ F Age_____ Date of Birth_____

Student ☐ Working ☐ Unemployed ☐ Retired ☐

Employer/School_____

Occupation_____

Single ☐ Married☐ Widowed ☐ Divorced ☐ Separated ☐

Spouse's Name (or parent for minors) _____

Patient Condition (you may add additional complaints on the additional complaints form)

Primary Complaint:_____

Is this condition due to an accident? YES / NO Auto ☐ Home☐ Work☐ Other☐ Date_____

Are you involved in or expect litigation concerning this accident? YES / NO

When did your symptoms first appear? _____ Is this condition getting worse? YES / NO

How often do you experience this problem? _____ Is it constant or does it come and go?_____

If daily, are you aware of it 0-25%, 26-50%, 51-75%, 76-100% of the time you are awake? Circle one

Activities which are difficult or more painful to perform due to this complaint:

What treatment have you already received for your condition?

Medication(s): Prescription ☐, OTC ☐, Herbals ☐, Name:_____ Did it help? Y / N

PT ☐, Surgery ☐, Chiropractic ☐, None, ☐ Other _____ Did it help? Y / N

Other treatments ie heat, ice etc _____ Did it help? Y / N

Name of other Doctor(s) who are currently treating you for this condition:_____

What makes the complaint worse?_____

What makes the complaint improve? _____

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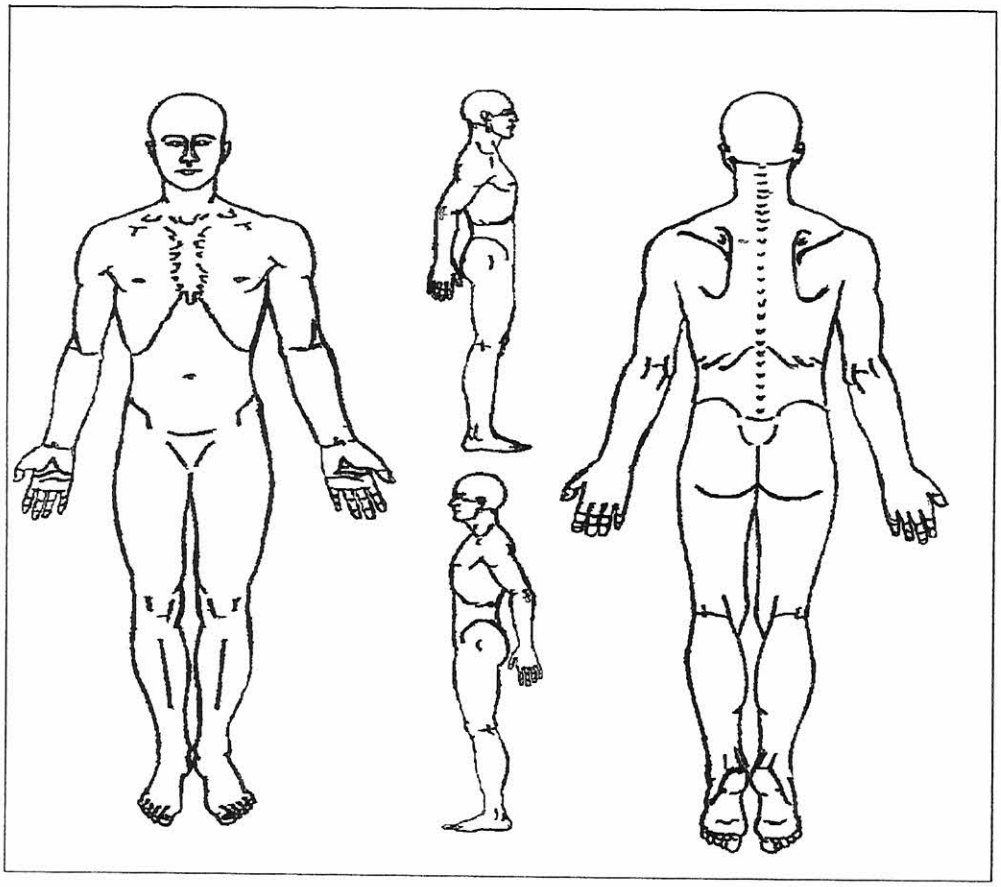
Location and Description of ALL Complaints

Mark the diagrams below to demonstrate the location of your pain/discomfort.

Use the following letters describing your pain to mark the location:

A= ache B= burning N= numbness P= pins and needles

S= stabbing O= other



Does any of your pain radiate or travel from the main source down your arm or leg? Please indicate on the above diagram with arrows.

Place a mark on the scales below to describe the intensity of your pain/discomfort over the last two weeks with "0" being no pain and 10 being the worst pain imaginable.

At Rest: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Activity: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Has this pain lasted for more than three months? (please circle) Yes or No

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Medications/Supplements/Allergies

Medications you are currently taking		Allergies		Vitamins/Herbs/Supplements
☐ Blood Pressure	☐ Diabetes	Pollen	☐	List:
☐ Birth Control	☐ Corticosteroids	Dust	☐	
☐ Muscle Relaxants	☐ Antibiotics	Ragweed	☐	
☐ Antidepressant	☐ Antianxiety	Latex	☐	
☐ Pain Medication	☐ Heart	Animals	☐	
☐ Cholesterol	☐ Osteoporosis	Other:		
Other:				

Personal Health History

Are you currently under the care of any other Doctor or Healthcare Provider? YES / NO
If yes, for what condition(s) _____

_____

Provider's Name:_____ Phone:_____

Have you ever received chiropractic care? YES / NO If yes, when was your last appointment?_____
Name of Previous Chiropractor:_____

Date of last: Chiropractic exam_____ Spinal X-ray_____ CT scan/MRI_____
Prostate exam/PSA_____ Mammogram_____ Pap smear_____
Stool exam for blood_____ Colonoscopy_____Gen Physical_____

Injuries/Surgeries:	Description	Date
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

Have you ever:	Description	Date
Lost Consciousness:		
Used a Cane/Crutches:		
Had Mental/Emotional Disorders:		
Been treated for Spine/Nerve Disorder:		
Been in an accident?		

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Patient Name:_____

Personal Health History, cont'd.

Are you pregnant? YES / NO / MAYBE Due Date:_____

How many: Pregnancies:_____ Live Births:_____ Miscarriages:_____

C P (C=current, P= past)	C P (C=current, P=past)	C P (C=current, P=past)
☐ ☐ Headaches	☐ ☐ Scoliosis	☐ ☐ Kidney Problems
☐ ☐ Migraines	☐ ☐ Irritable Bowel Syndrome	☐ ☐ Difficulty Urinating
☐ ☐ Sinus problems	☐ ☐ Crohn's Disease	☐ ☐ Prostate Problems
☐ ☐ Dizziness /vertigo	☐ ☐ Chronic Diarrhea	☐ ☐ Liver Problems/Hepatitis
☐ ☐ Neck Pain	☐ ☐ Chronic Constipation	☐ ☐ Diabetes Type I or Type II
☐ ☐ Thyroid Problems	☐ ☐ Gastric Reflux	☐ ☐ Cancer
☐ ☐ Ear Problems	☐ ☐ Ulcers	☐ ☐ Osteoporosis/Osteopenia
☐ ☐ Asthma	☐ ☐ Colon problems	☐ ☐ Arthritis
☐ ☐ Throat Problems	☐ ☐ Diverticulosis	☐ ☐ Chronic Cold or Cough
☐ ☐ Difficulty Breathing	☐ ☐ Menstrual Problems	☐ ☐ Fibromyalgia
☐ ☐ Chest Pain	☐ ☐ Pelvic Pain	☐ ☐ Skin Problems
☐ ☐ Mid Back/Rib Pain	☐ ☐ Heart Problems	☐ ☐ Easy Bruising
☐ ☐ Low Back Pain	☐ ☐ Poor Circulation	☐ ☐ Anxiety
☐ ☐ Shoulder/Arm Pain	☐ ☐ Vascular Problems	☐ ☐ Depression
☐ ☐ Wrist/Elbow/Hand Pain	☐ ☐ Stroke	☐ ☐ Unexplained Fatigue
☐ ☐ Hip/Leg/Foot Problems	☐ ☐ Hypertension/High BP	☐ ☐ Unexplained Weight Change
☐ ☐ Knee Problems	☐ ☐ Difficulty Swallowing	☐ ☐ Epilepsy/Seizures
☐ ☐ Loss of Consciousness	☐ ☐ Frequent Urination	☐ ☐ Restless Leg Syndrome

Other, please specify:_____

_____

_____

Tobacco Use (Smoking or smokeless): YES / NO

Alcohol Use (Beer / Wine / Hard liquor): YES / NO

Do you have any concerns about your sexual health? YES / NO

Are you or have you ever been a victim of domestic or sexual abuse? YES / NO

Do you exercise at least three times per week? YES / NO

Have you travelled internationally within the last year? (please circle) YES / NO

All answers I have provided are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at Pedersen Chiropractic at this time.

_____ _____

Patient's Signature Date

_____ _____

Signature of Parent or Legal Guardian Relationship