Integrative Health Inc
Experts Providing Healthcare

Chiropractic Questionnaire

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

This questionnaire is in addition to the initial intake form (which must have been completed within the last two years).

Patient Contact Information

Name: _____ Date: _____

DOB _____ Age: ____ ☐ Male ☐ Female If minor, name of parent: _____

Cell #(_____)_____ Employer: _____ Occupation:_____

Insurance: ☐ Self Pay ☐ Health Insurance Company:_____ ☐ Auto Injury (Date): _____

Previous Chiropractic History

Have you ever received Chiropractic Care? ☐ Yes ☐ No

What age was your 1st **professional** adjustment? Birth-1yr ○ 2-6 yrs ○ 7-12 yrs ○ 13-18yrs ○ Other: _____

Who was your last chiropractor? _____ What city/state? _____

How often were your visits? _____ When was your last adjustment? _____ Reason? _____

Current Care

On a scale of 1-10, rate your commitment to get rid of problem(s) and feel better? _____

Any concerns or fears about chiropractic? _____ If yes, what? _____

What are the goals of your chiropractic visits? 1. _____ 2. _____

What other treatments have you tried? _____

Additional Information: _____

Patient Condition

Please describe the location of your main symptom: _____

When did this start? _____

How did it start? _____

When was the most recent episode? _____

Describe the symptoms, dull/achy, sharp/stabbing, tightness, etc. _____

Do you feel symptoms down your arms or legs? _____

Does anything go numb, tingly or have weakness? Where? _____

Is this condition getting: ☐ better ☐ worse ☐ same Is it progressively getting worse? ☐ Yes ☐ No

Please rate the intensity from 1 to 10 (10=Worst) Now: _____ Average: _____ At its worst: _____

How often do you feel symptoms: ☐ Constant (100%) ☐ Frequent (75% of the time) ☐ Intermittent (50%) ☐ Occasional (25%)

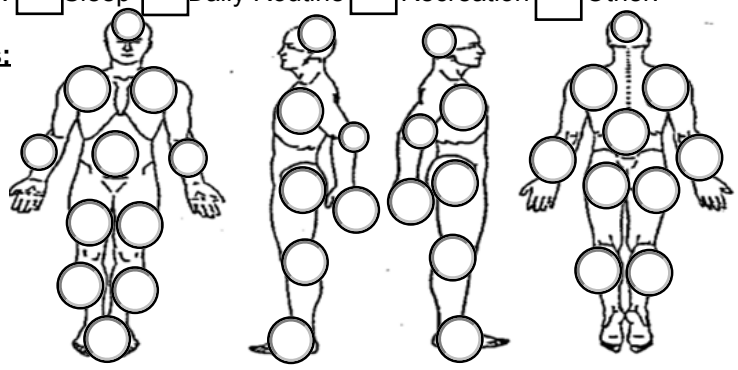
When (morning, night, after work, etc.) is it the worst? _____

What makes it better? _____

What makes it worse… sitting standing bending ? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other:

Circle where you feel symptoms:



Global Systems Chart Please indicate frequency of occurrence per day, week, month, etc. (Example: 2x/day or 1x/month)

Cervical (Neck) Area

Headaches or Migraines: _____
Dizziness/Lightheaded: _____
Blurred/Loss of Vision: _____
Sinus Congestion/Pain: _____
Ringing in ears (Which?): _____
Brain Fogginess: _____
Neck Tension/Pain: _____
TMJ/Jaw Tension/Pain: _____
Shoulder Tension/Pain: _____
Elbow Tension/Pain: _____
Wrist Stiffness/Pain: _____
Hand Stiffness/Pain: _____
Tingles/Numb Hands: _____
Swollen Hands: _____
Cold Hands: _____

Thoracic Area

Difficulty Swallowing: _____
Voice Change/Hoarseness: _____
Allergies (to what): _____
Asthma/breathing issues: _____
Chest pressure/Pain: _____

Heartburn/Reflux: _____
Gas/ Belching: _____
Nausea/Vomiting: _____
Pain between sh. Blades: _____

Lumbar/Low Back Area

Low Back Pain: _____
SI/Pelvis/Hip Pain: _____
Thigh/IT Band Pain: _____
Knee Pain (which?): _____
Sciatica (which leg?): _____
Calf Pain/Restless legs: _____
Ankle or Foot Pain: _____
Cold Feet (even w/ socks): _____
Tingling/Numbness in legs: _____
Constipation/Hard Stool: _____
Diarrhea/Rectal Bleeding: _____
Cannot fully void bladder: _____
Dribbles when cough/sneeze: _____
Bladder wakes from sleep: _____
Menstrual Cramping/PMS: _____
Infertility or Impotence: _____

Health History Please check any of the following you have had:

☐ Diabetes	☐ High/Low Blood Pressure	☐ Thyroid Problems	☐ Arthritis	☐ Stroke
☐ Cancer	☐ Chronic Fatigue	☐ Heart Disease	☐ Anxiety	☐ Epilepsy
☐ Depression	☐ Disc Herniation	☐ Osteoporosis	☐ AIDS/HIV	
☐ Concussion	☐ Weight Loss/Gain	☐ High Cholesterol	☐ Kidney Problems	