

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%)

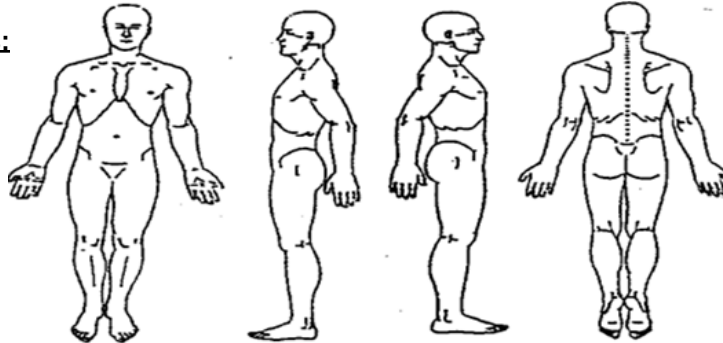
When (morning, night, after work, etc.) is it the worst? _____

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: _____

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: _____

Thoracic Area

Difficulty Swallowing: _____

Voice Change/Hoarseness: _____

Allergies (to what): _____

Asthma/breathing issues: _____

Chest pressure/Pain: _____

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

- | | | | | |
|-------------------------------------|--|---|--|-----------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Disc Herniation | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> AIDS/HIV | |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Problems | |

