Active Care Family Chiropractic

113 South Main St. Summerville ◆ 628 Saint Andrews Blvd. Suite 2 Charleston

Release Your Pain Improve Your Performance

HEALTH QUESTIONNAIRE

TO SAVE TIME AND TO ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS

CONFIDENTIAL CASE HISTORY

PLEASE PRINT DR. MR. MRS. MS. MISS TODAY'S DATE_____

NAME:_____CELL#_____WORK#_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SS#_____ DATE OF BIRTH:_____AGE:_____SEX: M F

OCCUPATION:_____EMPLOYER:_____YRS EMPLOYED:_____

MARITAL STATUS:_____ SPOUSE'S NAME_____SPOUSE'S DATE OF BIRTH_____

IF RETIRED, FORMER OCCUPATION_____EDUCATION LEVEL OBTAINED_____

PRIMARY CARE PHYSICIAN(NAME, ADDRESS, PHONE#)_____

_____

WHO CAN WE CONTACT IN CASE OF EMERGENCY?_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

_____

MAIN COMPLAINT: WHY ARE YOU HERE TODAY? BE SPECIFIC WITH LOCATION_____

_____

1.WHEN DID IT START? DATE:_____

2.HOW DID IT START? EXPLAIN:_____

3.ARE TODAY'S COMPLAINTS THE RESULT OF A: WORK RELATED INJURY? AUTO ACCIDENT? HOME INJURY? Y / N

4.DOES IT RADIATE TO ANY OTHER PART OF YOUR BODY? YES NO WHERE?_____

5.DID IT BEGIN GRADUALLY OR SUDDENLY?_____

6.RATE THE SEVERITY OF YOUR PAIN:(0= NO PAIN to 10=EXCRUCIATING) PLEASE CIRCLE 1 2 3 4 5 6 7 8 9 10

7.DESCRIBE YOUR PAIN: DULL SHARP BURNING NUMBNESS SORENESS STIFFNESS OTHER_____

8.HAS YOUR PROBLEM BEEN GETTING: BETTER WORSE or STAYING THE SAME?_____

9.DOES YOUR CONDITION COME AND GO OR IS IT ALL THE TIME?_____

10.WHAT MAKES YOUR SYMPTOMS BETTER?_____

11.WHAT MAKES YOUR SYMPTOMS WORSE?_____

12.HAVE YOU TRIED HOME REMEDIES? YES NO WHAT?_____

13.WHAT DOCTORS HAVE YOU SEEN AND WHAT TESTS HAVE BEEN DONE FOR YOUR CONDITION?_____

_____

14.HAVE YOU HAD ANYTHING LIKE THIS BEFORE?_____

15.HAVE THERE BEEN ANY CHANGES IN BOWEL OR BLADDER FUNCTIONS? YES NO DETAILS_____

16.DOES YOUR CONDITION INTERFERE WITH: PLEASE CIRCLE: WORK SLEEP DAILY ROUTINE RECREATION

DOCTOR'S INITIALS_____

NAME:_____TODAY'S DATE:_____

17. ACTIVITIES THAT ARE PAINFUL TO PERFORM: SITTING STANDING WALKING BENDING LAYING DOWN
18. HAVE YOU BEEN UNABLE TO WORK AS A RESULT OF YOUR CURRENT PROBLEM?_____
19. DO YOU HAVE ANY OTHER PROBLEMS YOU WANT THE DOCTOR TO EVALUATE?_____

PAST HISTORY:

1. HAVE YOU HAD ANY OF THE FOLLOWING CHILDHOOD DISEASES: MEASLES RUBELLA CHICKENPOX MUMPS SCARLET FEVER RHEUMATIC FEVER TUBERCULOSIS OTHER?_____
2. HAVE YOU BEEN DIAGNOSED WITH ANY OTHER CONDITIONS? EXPLAIN_____
3. ARE YOU UNDER A DOCTOR'S CARE PRESENTLY FOR ANY TYPE OF HEALTH PROBLEM?_____
4. HAVE YOU HAD ANY BROKEN BONES? YES NO WHICH ONES?_____
5. HAVE YOU EVER HAD ANY SIGNIFICANT AUTO ACCIDENTS, WORK INJURIES OR FALLS? YES / NO WHEN?_____
6. ARE YOU TAKING ANY MEDICATIONS? YES NO WHICH ONES?_____
7. HAVE YOU EVER UNDERGONE ANY TYPE OF SURGERY? YES NO WHAT & WHEN_____
8. DO YOU EAT REGULAR MEALS? YES NO HOW MANY PER DAY?_____SNACKS PER DAY?_____
9. DO YOU SMOKE, DRINK ALCOHOL, CAFFEINE OR USE RECREATIONAL DRUGS?_____
10. DO YOU TAKE VITAMINS OR NUTRITIONAL SUPPLEMENTS?_____
11. DO YOU HAVE ANY ALLERGIES?_____
12. DO ANY DISEASES RUN IN YOUR FAMILY?_____
13. HOW OFTEN DO YOU EXERCISE? _____
14. DESCRIBE YOUR WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR
15. HOW MANY HOURS PER NIGHT DO YOU USUALLY SLEEP?_____HOW DO YOU SLEEP? BACK SIDE STOMACH
16. DO YOU WEAR: HEEL LIFTS SHOE LIFTS ARCH SUPPORTS ORTHOTICS

HAVE YOU BEEN DIAGNOSED OR BEEN TOLD YOU HAVE ANY OF THE FOLLOWING?

YES	NO	HIGH BLOOD PRESSURE
YES	NO	HARDENING OF THE ARTERIES
YES	NO	DIABETES
YES	NO	HEART OR BLOOD VESSEL DISEASE
YES	NO	BONE SPURS ON THE NECK
YES	NO	WHIPLASH INJURY
YES	NO	ANY RELATIVE SUFFER A STROKE
YES	NO	BLURRED VISION
YES	NO	DOUBLE VISION
YES	NO	CURRENTLY SMOKE?
YES	NO	HAVE YOU SMOKED IN THE PAST?
YES	NO	SUDDEN COLLAPSE W/O LOSS OF CONSCIOUSNESS
YES	NO	DIMINISHED OR PARTIAL LOSS OF VISION ONE OR BOTH EYES

HAVE YOU HAD ANY OF THESE FOLLOWING SYMPTOMS FOR EVEN A SHORT OR TEMPORARY DURATION WITHIN THE PAST YEAR?

YES	NO	SLURRED SPEECH / SPEECH PROBLEMS
YES	NO	DIFFICULTY SWALLOWING
YES	NO	DIZZINESS
YES	NO	TEMPORARY LACK OF UNDERSTANDING
YES	NO	LOSS OF CONSCIOUSNESS, EVEN MOMENTARY BLACKOUTS
YES	NO	NUMBNESS OR LOSS OF SENSATION IN THE FACE, ARMS, HANDS, OR LEGS
YES	NO	WEAKNESS, CLUMSINESS, OR STRENGTH LOSS IN THE FACE ARMS HANDS OR LEGS
YES	NO	HEARING LOSS IN ONE OR BOTH EARS

DOCTOR'S INITIALS_____

NAME:_____DATE:_____

GENERAL SYMPTOMS: PLEASE CHECK ANY THAT APPLY TO YOU.

GENERAL

- ☐BRUISE EASILY
- ☐CHILLS
- ☐DENTAL PROBLEMS
- ☐DEPRESSION
- ☐DIZZINESS
- ☐FAINTING
- ☐FEVER
- ☐FORGETFULNESS
- ☐HEADACHE
- ☐LOSS OF SLEEP
- ☐NERVOUSNESS
- ☐SWEATS
- ☐TIREDNESS
- ☐WEIGHT GAIN

GASTROINTESTINAL

- ☐APPETITE POOR
- ☐BLOATING
- ☐BOWEL CHANGES
- ☐CONSTIPATION
- ☐DIARRHEA
- ☐EXCESSIVE HUNGER
- ☐EXCESSIVE THIRST
- ☐GAS
- ☐HEMORRHOIDS
- ☐INDIGESTION
- ☐NAUSEA
- ☐RECTAL BLEEDING
- ☐STOMACH PAIN
- ☐VOMITING
- ☐VOMITING BLOOD

EYE, EAR, NOSE, THROAT

- ☐BLEEDING GUMS
- ☐BLURRED VISION
- ☐CROSSED EYES
- ☐DIFFICULTY SWALLOWING
- ☐DOUBLE VISION
- ☐EARACHE
- ☐EAR DISCHARGE
- ☐HAY FEVER
- ☐HOARSENESS
- ☐LOSS OF HEARING
- ☐NOSEBLEEDS
- ☐PERSISTENT COUGH
- ☐RINGING IN EARS
- ☐SINUS PROBLEMS
- ☐VISION FLASHES
- ☐VISION HALOS

MEN ONLY

- ☐BREAST LUMP
- ☐ERECTION DIFFICULTIES
- ☐LUMP IN TESTICLES
- ☐PENIS DISCHARGE
- ☐SORE ON THE PENIS
- ☐OTHER_____
- ☐DIFFICULTY W/ URINATION
- ☐EXCESSIVE URINATION

DATE OF LAST PROSTATE EXAM

_____

WOMEN ONLY

- ☐ABNORMAL PAP SMEAR
- ☐BREAST LUMP
- ☐HOT FLASHES
- ☐NIPPLE DISCHARGE
- ☐PAINFUL INTERCOURSE
- ☐VAGINAL DISCHARGE
- ☐BLEEDING BETWEEN PERIODS
- ☐EXTREME MENSTRUAL PAIN
- ☐OTHER_____

DATE OF LAST PERIOD_____

DATE OF LAST PAP SMEAR_____

CARDIOVASCULAR

- ☐CHEST PAIN
- ☐HIGH BLOOD PRESSURE
- ☐IRREGULAR HEART BEAT
- ☐LOW BLOOD PRESSURE
- ☐POOR CIRCULATION
- ☐RAPID HEART BEAT
- ☐SWELLING OF ANKLES
- ☐VARICOSE VEINS

SKIN

- ☐HIVES
- ☐ITCHING
- ☐CHANGES IN MOLES
- ☐RASH
- ☐SCARS
- ☐SORE THAT WON'T HEAL

HAVE YOU HAD A MAMMOGRAM YES NO

DO YOU TAKE BIRTH CONTROL PILLS YES NO

IF YES, HOW LONG_____

ARE YOU PREGNANT YES NO

HOW MANY CHILDREN?_____

ATTENTION:Payment is to be made at the time of the visit unless prior arrangements have been made with this office. Also, 24-hour notice is necessary to cancel an appointment, and you may be responsible for payment of a missed appointment.

I hereby consent to any procedures or treatments necessary for treatment of any condition as deemed reasonable by the attending doctor.

PATIENT SIGNATURE:_____**DATE:**_____

DOCTOR'S INITIALS_____