

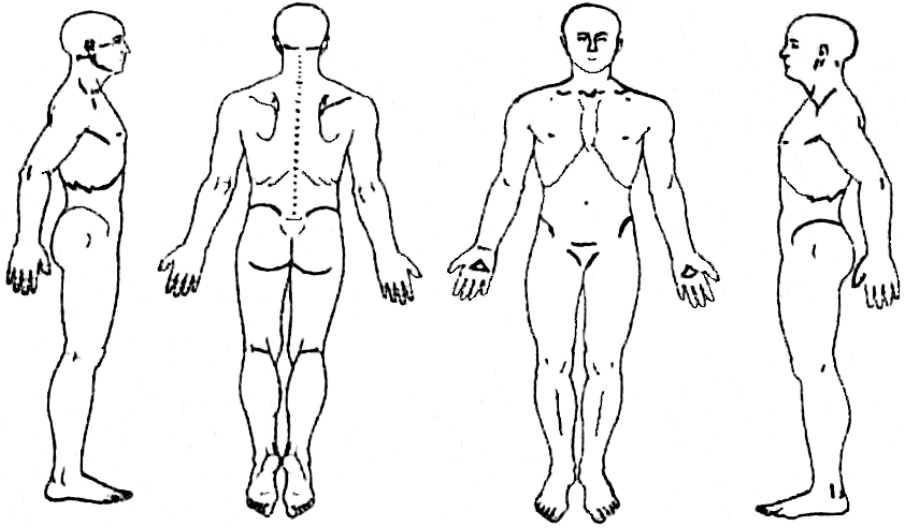
Confidential Health Questionnaire

Patient Name _____ Today's Date _____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell/Additional Phone _____
Work Phone _____ Date of Birth _____ E-mail _____
Social Security # _____ If married - Spouse's name _____

1. Reason for Visit _____
2. Please describe your current symptoms _____
3. Date symptoms began _____ Related to Work Injury Auto Accident Other _____
4. Describe how your symptoms began _____

Indicate where you have pain or other symptoms

- 5. How often do you experience your symptoms?
 Constantly (76-100% of the day)
 Frequently (51-75% of the day)
 Occasionally (26-50% of the day)
 Intermittently (0-25% of the day)
6. What describes the nature of your symptoms?
 Sharp Shooting
 Dull ache Burning
 Numb Tingling
7. How are your symptoms changing?
 Getting Better
 Not Changing
 Getting Worse



8. Current medications: Advil Tylenol
 Other/s _____

9. Indicate the average intensity of your complaints
None 0 1 2 3 4 5 6 7 8 9 10 Unbearable
(Choose One)

10. What makes your symptoms feel better? _____
11. What makes your symptoms feel worse? _____
13. Who have you seen for your current symptoms?
 No one Medical Doctor Osteopath Physical Therapist
 Chiropractor Other _____
a. Tests performed? X-rays date _____ CT scan date _____ MRI date: _____ Other, date _____
b. Describe treatment _____
13. Have you had similar symptoms in the past? No Yes (explain) _____

a. Who did you see? No one Medical Doctor Physical Therapist Osteopath Other Chiropractor This Office
14. How did you here about our office? Walked by Yellow pages Web site: (which one) _____
 Friend is a patient Family member is a patient Medical doctor Chiropractor

15. Who may we thank for referring you? _____
Patient's / Guardian's Signature _____ Date _____