HEALTH QUESTIONNAIRE

CURRENT SYMPTOMS

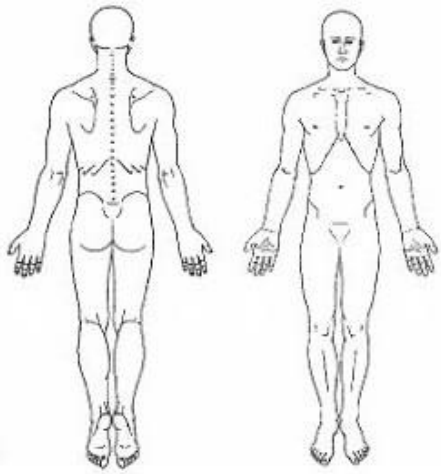
Describe your current problem and HOW / WHEN it began:

_____

_____

_____

Circle the areas of complaint



IS THIS? □ Work Related □ Auto Related □N/A

Current Complaint Level (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain **Moderate Pain** **Unbearable Pain**

How often are your symptoms present? □ 0-25% □ 26-50% □ 51-75% □ 76-100%

Are the symptoms: □ Improving □ Getting Worse □ About the Same □ Intermittent

Have you seen another doctor for this condition? □ MD □ Chiropractor □ Osteopath □ Dentist □ Podiatrist

Doctor's Name _____ Date Seen _____ Diagnosis _____

Can you perform your daily activities? □ Yes □ No (Describe) _____

HAVE YOU HAD AN X-RAY, MRI OR CT SCAN? □ NO □ YES **BODY PART(S):** _____

TAKEN AT: □ Pueblo □ Cottage □ Sansum □ Rolling Oaks □ Grossman □ Other:_____**YEAR TAKEN: _____**

Please check all of the following that apply to you:

Yes	No	Condition	Yes	No	Condition
□	□	History of Recent Infection	□	□	Recent Trauma
□	□	Recent Fever	□	□	Prostate Problems
□	□	HIV / AIDS	□	□	Frequent Urination
□	□	Osteoporosis	□	□	Pregnancy, # of births _____
□	□	Diabetes	□	□	Abnormal weight □ gain □ loss
□	□	Birth Control Pills	□	□	Epilepsy/Seizures
□	□	High Blood Pressure	□	□	Visual Disturbances
□	□	Stroke (date)_____	□	□	History of Low/Mid Back Pain
□	□	Dizziness/Fainting	□	□	History of Neck Pain
□	□	Numbness in Groin/Buttocks	□	□	Arthritis
□	□	Urinary Retention	□	□	History of Alcohol Use
□	□	Aortic Aneurysm	□	□	History of Tobacco Use
□	□	Cancer/ Tumor	□	□	Surgeries _____
□	□	Corticosteroid Use	□	□	Medications _____

Family History: □ Cancer □ Diabetes □ High Blood Pressure □ Cardiovascular Problems/Stroke

What is your goal to achieve by the end of therapy?_____