Scherping Chiropractic

Chiropractic Health Questionnaire

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: ____ Zip: _____

Birth Date: _____ Social Security #: _____

Home Phone: _____ Email address: _____

Work Phone #: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse: _____ # of children: ___

In case of emergency, contact: (name and phone number) _____

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ Referral: _____

MAJOR COMPLAINT INFORMATION

What is your reason for contacting us? _____

When did this begin? _____ ☐ Yes ☐ No – Have you had this before?

What aggravates it? _____ What helps it? _____

☐ Yes ☐ No – Does this condition interfere with your sleep?

☐ Yes ☐ No – Do any other symptoms accompany this? Please list: _____

_____

☐ Yes ☐ No – Have you seen another Doctor for this? Doctor's name and specialty: _____

_____ Date consulted: _____ Diagnosis: _____

Did this develop from? ☐ an auto accident ☐ a work injury ☐ don't know (chronic) ☐ other _____

PHYSICAL HEALTH HISTORY

Height: _____ Current weight: _____ ☐ Yes ☐ No – Any recent weight changes?

☐ Yes ☐ No ☐ Not sure – If female are you pregnant? If so, when is your due date: _____

Please list and describe any past injuries or accidents (including auto accidents, work and sport injuries, etc.)

_____

_____

_____

When was your last spinal examination? _____ ☐ Never

How many times have you visited a chiropractor in your lifetime?_____ ☐ Never

MEDICAL HISTORY

Surgeries ☐ None

Procedure _____Date _____Doctor/Hospital _____

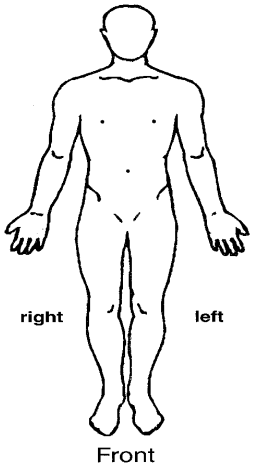
Procedure _____Date _____Doctor/Hospital _____

Prescription medications may cause various side effects, hide the severity of health conditions and/or hinder the body's ability to heal. Please list all prescription and over-the-counter medications (including frequency and dosage) you have taken within last year: _____

_____

_____

PLEASE MARK ANY AREAS WHERE SYMPTOMS ARE PRESENT AND DESCRIBE BELOW (type of pain [sharp, dull, achy, throbbing] and the intensity on a 1-10 scale when it is worst, i.e. sharp, shooting – 6):



Description: _____

_____

_____

_____

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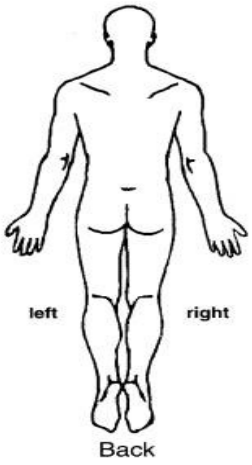

Please indicate if you have or had any of the following:

☐ Now ☐ Past – Hypertension
☐ Now ☐ Past – Kidney Disease
☐ Now ☐ Past – Memory loss
☐ Now ☐ Past – Osteoporosis
☐ Now ☐ Past – Sinus congestion
☐ Now ☐ Past – Ulcers
☐ Now ☐ Past – Diabetes
☐ Now ☐ Past – Headaches
☐ Now ☐ Past – Arthritis
☐ Now ☐ Past – Carpal Tunnel
☐ Now ☐ Past – Anxiety
☐ Now ☐ Past – Chemical Dependency
☐ Now ☐ Past – Irritable
☐ Now ☐ Past – Liver disease
☐ Now ☐ Past – Multiple Sclerosis
☐ Now ☐ Past – Ringing in ears
☐ Now ☐ Past – Tumors / Growths
☐ Now ☐ Past – Vertigo
☐ Now ☐ Past – Digestive troubles
☐ Now ☐ Past – Heart Disease
☐ Now ☐ Past – Bleeding disorder
☐ Now ☐ Past – Anemia
☐ Now ☐ Past – Alcoholism
☐ Now ☐ Past – Jaw pain
☐ Now ☐ Past – Loss of Balance
☐ Now ☐ Past – Nail Changes
☐ Now ☐ Past – Shortness of Breath
☐ Now ☐ Past – Asthma
☐ Now ☐ Past – Depression
☐ Now ☐ Past – Fatigue
☐ Now ☐ Past – High Cholesterol
☐ Now ☐ Past – Cancer
☐ Now ☐ Past – Anorexia/Bulimi
☐ Now ☐ Past – PMS

☐ Yes ☐ No – Do you have or have you ever had any disease or medical problems not listed? Please List: _____

_____

SIGNATURE

I certify that the above information is complete and correct to the best of my knowledge. I will not hold my doctor or any staff member of Scherping Chiropractic PA responsible for any inaccuracies, errors or omissions that I may have made in completing this form.

_____ _____

Patient Signature Date