

Adult Chiropractic Health Questionnaire

Welcome to our practice! Please complete all of the questions thoroughly. All information you share with us is confidential.

HFC

Horn Family
Chiropractic

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

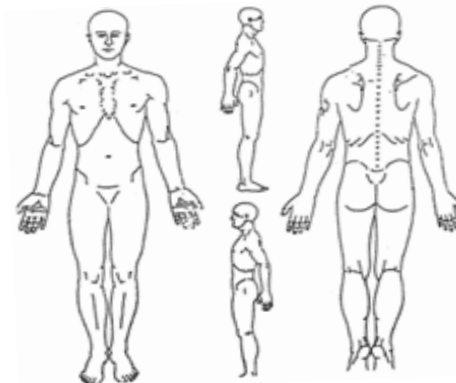


Name _____ Home Phone _____
Address _____ Work Phone _____
City, State, Zip _____ Cell Phone _____
Birth date _____ Age _____ E-mail Address _____
SS# _____ Primary Doctor _____ Phone # _____
Occupation _____ Employer _____
Marital Status: M W Sep. D Sin. Spouse Name _____ No. of Children _____

1. Please list where you are having your pain? (i.e.: neck, mid back, headaches, low back, legs, arms, shoulder, right or left etc.) _____
2. When did your problem begin: Specific date if possible? What do you feel caused your pain to occur? _____

a. **Description:** b. **Frequency (% during day)** **MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN OR OTHER SYMPTOMS**

<input type="checkbox"/> Sharp Pain	<input type="checkbox"/> Numb	<input type="checkbox"/> Constant (76-100%)
<input type="checkbox"/> Dull Pain	<input type="checkbox"/> Shooting	<input type="checkbox"/> Frequent (51-75%)
<input type="checkbox"/> Ache	<input type="checkbox"/> Gripping	<input type="checkbox"/> Occasional (26-50%)
<input type="checkbox"/> Weak	<input type="checkbox"/> Burning	<input type="checkbox"/> Intermittent (25% or less)
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Tingling	
<input type="checkbox"/> Cramps	<input type="checkbox"/> Stiffness	
<input type="checkbox"/> Other: _____		



3. Please rate your pain at the lowest and highest level: NONE 0 1 2 3 4 5 6 7 8 9 10 SEVERE
4. Your symptoms are currently: increasing decreasing not changing
5. Symptoms are worse in the morning afternoon night increase during the day same all day
6. What makes your problem worse? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity Other _____
7. What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity Other _____
8. Have you been treated in the past or currently (Please circle) for this same or similar problem?
 Yes No If yes, by whom? Chiropractor MD Osteopath Physical Therapist
 Occupational Therapist Other _____
9. How would you rate your general stress level? NO Stress Minimal Stress
 Moderate Stress Greatly Stressed
10. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent
11. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? Y N

12. Are your complaints affecting your ability to be active? No effect Some physical restrictions (able to perform light duty work and household tasks) Need limited assistance with common everyday tasks Need assistance often have significant inability to function w/o assistance am totally disabled(impaired) Cannot care for self
13. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or back? Y N
14. What spine surgeries have you had? Neck, back, hip, shoulder, etc. _____
15. Do you exercise? Y N How often? _____ Type: _____
16. Have you ever been told that you have a spinal curvature, spinal arthritis or other spinal problems? Y N
17. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? Y N
18. When was your last complete spinal examination including X-rays? _____
19. Auto and work injuries can cause serious spinal problems. Is this visit related to an accident or injury? Y N Date of Incident _____
20. Do any members of your family suffer from the same or similar problems? Y N

Please indicate with a (C) **Conditions you have now** or with a (P) the conditions you have **had in the past**.

<input type="checkbox"/> Skin Problems <input type="checkbox"/> Frequent Colds, Flu <input type="checkbox"/> Irritability <input type="checkbox"/> Anemia <input type="checkbox"/> Allergy, Sinus <input type="checkbox"/> Under Stress/Tension <input type="checkbox"/> Blurred, Double vision <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Pain with Cough, Sneeze <input type="checkbox"/> Headaches <input type="checkbox"/> Chest Pain, asthma	<input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Trouble Concentrating <input type="checkbox"/> Mood Changes <input type="checkbox"/> Neck Pain or Stiffness (R L) <input type="checkbox"/> Numbness, Tingling, Pain in arms, hands, fingers (R L) <input type="checkbox"/> Jaw Pain or Click (TMJ) (R L) <input type="checkbox"/> Difficulty in excessive standing, sitting, riding, bending, lifting, twisting <input type="checkbox"/> Shoulder Pain (R L)	<input type="checkbox"/> Upper Back Pain, stiffness <input type="checkbox"/> Mid-back Pain, stiffness <input type="checkbox"/> Lower-back Pain, stiffness <input type="checkbox"/> Hip pain (R L) <input type="checkbox"/> Numbness, tingling, pain in buttocks, legs, feet, toes (R L) <input type="checkbox"/> Foot Trouble (R L) <input type="checkbox"/> Impotence <input type="checkbox"/> Menstrual Problems, PMS <input type="checkbox"/> AIDS, HIV
<input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Low Resistance <input type="checkbox"/> Fatigue <input type="checkbox"/> Ulcers <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Heart Problems <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression	<input type="checkbox"/> Loss of Bladder Control <input type="checkbox"/> Loss of Bowel Control <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Digestion Problems <input type="checkbox"/> Nausea <input type="checkbox"/> Speech Difficulty <input type="checkbox"/> Irritability	<input type="checkbox"/> Prostate Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Hands/Feet Cold <input type="checkbox"/> Hand Tremors <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Nervousness <input type="checkbox"/> Sweaty Palms

21. Do you suffer from any of the following? (Please circle Y or N)

<input type="checkbox"/> Y N Broken/Fractured Bones <input type="checkbox"/> Y N Circulatory Problems <input type="checkbox"/> Y N Diabetes <input type="checkbox"/> Y N Hearing Loss <input type="checkbox"/> Y N High/Low Blood Pressure <input type="checkbox"/> Y N Learning Disability <input type="checkbox"/> Y N Liver Trouble <input type="checkbox"/> Y N Hemorrhoids	<input type="checkbox"/> Y N Seizures/Convulsions <input type="checkbox"/> Y N A Congenital Disease <input type="checkbox"/> Y N Excessive Bleeding <input type="checkbox"/> Y N Osteoarthritis <input type="checkbox"/> Y N Epilepsy <input type="checkbox"/> Y N Pacemaker <input type="checkbox"/> Y N Stroke <input type="checkbox"/> Y N Cancer	<input type="checkbox"/> Y N Coughing Blood <input type="checkbox"/> Y N Eating Disorder <input type="checkbox"/> Y N Alcoholism <input type="checkbox"/> Y N Drug Addiction <input type="checkbox"/> Y N Gall Bladder <input type="checkbox"/> Y N Tumors <input type="checkbox"/> Y N Varicose Veins <input type="checkbox"/> Y N Rheumatoid Arthritis <input type="checkbox"/> Y N Ruptures
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Would you like to receive our weekly health and wellness newsletter via e-mail? Y N

What are your hobbies? _____

If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations? Y N

How will you be paying for your visit? Cash _____ Check _____ Credit/Debit _____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement. I understand that all fees are due and payable at the time of service.

Patient or Guardian Signature: _____ Date: ____ / ____ / ____