Mercer Island CHIROPRACTIC

HEALTH QUESTIONAIRE

Patient Name: _____ *Pt # (Office Use Only):* _____

Date of Birth: _____ S.S. #: _____ Sex: □Male □Female

Home Address *(please no P.O. Box #s)*:

_____ City: _____ State: _____ Zip:_____

HM Phone: _____ Cell Phone: _____

E-mail: _____

Place of Employment _____ WK Phone _____

How may we communicate with you? □HM Phone □Cell Phone □Wk Phone □Email

Marital Status: □Single □Married □Divorced □Widow □Other

Insurance Company Name: _____ ID#_____
Name of Insured: _____ Date of Birth_____
How did you hear about our office? _____

In Case of an Emergency, Contact:

Name: _____ Relationship: _____

HM Phone: _____ Cell Phone: _____ Wk Phone: _____

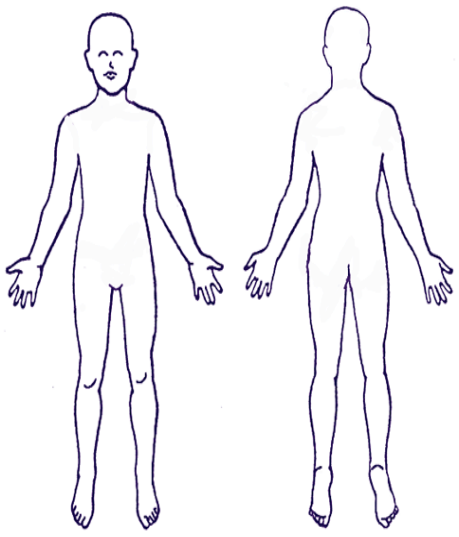
Dear Patients: Please complete this questionnaire. Your answers will help us determine if we can help you if we can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. Thank you.

A.) MAJOR COMPLAINTS:

1.) What are your major complaints?

□None	Pain	Numbness	Tingling
Head	□	□	□
Neck	□	□	□
Upper Back	□	□	□
Mid Back	□	□	□
Lower Back	□	□	□

	R	L	R	L	R	L
Shoulder	□	□	□	□	□	□
Arm	□	□	□	□	□	□
Forearm	□	□	□	□	□	□
Hand	□	□	□	□	□	□
Buttock	□	□	□	□	□	□
Hip	□	□	□	□	□	□
Thigh	□	□	□	□	□	□
Leg	□	□	□	□	□	□
Foot	□	□	□	□	□	□



Mark the location of the pain on these figures

2.) Currently your pain is aggravated by:

- ☐Coughing
- ☐Sneezing
- ☐Straining at Stool
- ☐Neck Movement
- ☐Reaching
- ☐Other
- ☐Lifting
- ☐Bending
- ☐Sitting
- ☐Standing
- ☐Walking

3.) Since your symptoms began, have you noticed a change in:

- ☐Bowel Function
- ☐Bladder Function
- ☐Ability to maintain an erection

B.) REVIEW OF SYMPTOMS:

a.) GENERAL ☐Normal ☐Chills ☐Weakness ☐Night Sweats ☐Fatigue ☐Weight Change ☐Fever ☐Other	**b.) SKIN** ☐Normal ☐Eczema ☐Rash ☐Hair Changes ☐Redness ☐Nail Changes ☐Itching ☐Other
c.) NEUROLOGIC ☐Normal ☐Fainting ☐Convulsions ☐Dizziness ☐Headaches ☐Migraines ☐Other	**d.) EYES** ☐Normal Left / Right Vision Trouble ☐ ☐ Discharge ☐ ☐ Pain ☐ ☐ Other ☐ ☐
e.) EARS ☐Normal Left / Right Hearing Trouble ☐ ☐ Ringing ☐ ☐ Discharge ☐ ☐ Pain ☐ ☐ Other ☐ ☐	**f.) NOSE** ☐Normal ☐Pain ☐Bleeding ☐Absence of Smell ☐Other
g.) MOUTH/THROAT ☐Normal ☐Absence of Taste ☐Sores ☐Abnormal Taste ☐Bleeding ☐Other	**h.) HEART/LUNGS** ☐Normal ☐Blue Extremities ☐Cough ☐Swollen Extremities ☐Palpitations ☐Difficulty Breathing ☐Wheezing ☐Chest Pain ☐Murmur ☐Other
i.) BREASTS ☐Normal ☐Dimpling ☐Lumps ☐Discharge ☐Pain ☐Redness/Itching ☐Other	**j.) STOMACH/INTESTINES** ☐Normal ☐Abdominal Pain ☐Diarrhea ☐Decreased Appetite ☐Constipation ☐Increased Appetite ☐Vomiting ☐Other
k.) REPRODUCTIVE ☐Normal ☐Inability to Hold Urine ☐Impotence ☐Painful Menstruation ☐Sterility ☐Abnormal Vaginal Bleeding ☐Other	**l.) GLANDULAR** ☐Normal ☐Goiter ☐Tremor ☐Heat/Cold Intolerance ☐Frequent Urination ☐Inability to Hold Urine ☐Sugar in Urine ☐Inability to Hold Urine ☐Other
m.) MENTAL ☐Normal ☐Phobias ☐Depression ☐Memory Loss or Impairment ☐Anxiety ☐Mood Swings ☐Other	

-OVER-

C.) MEDICAL HISTORY

1.) What are your Health Habits?

Do you smoke?	□Never	□Occasional	□Moderate	□Excessive
Do you drink alcohol?	□Never	□Occasional	□Moderate	□Excessive
Do you drink coffee?	□Never	□Occasional	□Moderate	□Excessive
Do you exercise?	□Never	□Occasional	□Moderate	□Excessive

2.) Have you ever been adjusted by a Chiropractor before?

□Yes □No If Yes, when? _____

Reason for visits: _____

Doctor's name: _____

Has *any* adult in your family seen a Chiropractor? □Yes □No
Has *any* child in your family seen a Chiropractor? □Yes □No

3.) Medications: Please list any medications, allergies, vitamins/herbs that you are taking:

_____ _____

_____ _____

_____ _____

4.) Which of the following Illnesses have you had?

□No Previous Conditions	□Arthritis	□Asthma	□Sinus Trouble
□Hay Fever	□Allergies	□Tuberculosis	□Diabetes
□Epilepsy	□Thyroid Trouble	□High Blood Pressure	□Low Blood Pressure
□Heart Trouble	□HIV/AIDS	□Ulcer	□Cancer
□Sexually Transmitted Disease	□Polio	□Rheumatic Fever	□Serious Injury
□Bone Fracture	□Dislocated Joint	□Spinal Disc Disease	□Multiple Sclerosis
□Scoliosis	□Prostate Trouble	□Kidney Trouble	□Mental Difficulty

□Other: _____

_____

5.) Goals for my Care:

People see Chiropractors for a variety of reasons. Some people go for relief of pain, some to correct the cause of pain and others for the correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your treatment plan. Please check the type of care desired, so that we may be guided to your wishes.

□ **Relief Care**:	Symptomatic relief of pain and discomfort
□ **Corrective Care**	Corrective and relieving the cause of the problem as well as the symptom
□ **Comprehensive Care**	Bringing whatever is malfunctioning in the body to highest state of health possible with Chiropractic Care.

□ I want the doctor to select the type of care appropriate for my condition

_____ _____
Patient or Legal Guardian Signature Date