

HEALTH HISTORY QUESTIONNAIRE

Personal Information

Name:	<input type="checkbox"/> F <input type="checkbox"/> M	DOB:
Primary Care Provider:	Address:	
Referring Provider:	Address:	
Pain Management Provider:	Address:	
Specialty Provider:	Address:	
For what problem are you requesting a consultation:		
Have you been treated for this problem in the past and if so by whom:		
Which of these have you tried for this problem: <input type="checkbox"/> PT Name and address: <input type="checkbox"/> Chiropractic Care Name and address:		

Social History

Work status: <input type="checkbox"/> Employed _____ <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
Tobacco use: <input type="checkbox"/> Never smoked <input type="checkbox"/> Former Smoker, quit use _____ <input type="checkbox"/> Every day smoker: ppd/years _____	
Alcohol use: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Current Height: _____	Current Weight: _____

Current Medications *list prescription medications as well as non-prescription meds and vitamins/supplements*

Preferred Pharmacy:		
Drug Allergies: <input type="checkbox"/> None		
Medication	Strength/Dose	Frequency

Past Medical History

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Seizure	<input type="checkbox"/> Headaches
<input type="checkbox"/> Angina/chest pain	<input type="checkbox"/> RSD	<input type="checkbox"/> Stroke	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Brain Tumor	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Gout	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Valve Replacement	<input type="checkbox"/> GERD	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Dementia	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Other:

Family History

Disorder	Family Member
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Coronary Artery Disease	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Bleeding Disorder	_____
<input type="checkbox"/> Blood Clots	_____
<input type="checkbox"/> Heart Attack	_____

Surgical History

Surgery	Date	Doctor/Facility

Review of Systems What symptoms are you currently experiencing?

<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Headache
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Numbness location:
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Weakness location:
<input type="checkbox"/> Vision changes	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other symptoms you are experiencing:
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Muscle pain/ache	
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Neck pain	
<input type="checkbox"/> Cough	<input type="checkbox"/> Back pain	