Active Living
HEALTH CENTER

Health Questionnaire

1: Patient Information

First name: _____Last name: _____ Nick name:_____

Address: _____

City: _____ State: _____ Zip code: _____

Primary phone: _____ Secondary phone: _____

Home email: _____ Work email: _____

By providing my email address, I authorize my doctor to contact me via email address(es) provided.

Which email address would you like us to use to communicate with you? (check one) □Home □Work

Contact method (check one): □ Primary Phone □ Secondary Phone □ Home Email □ Work Email

Referred by: □ Patient/Friend □ Physician □ Advertisement □ Student □ Community Event □ Sports Event

Name of person or event: _____

Date of birth: ____ / ____ / _____ Age: _____ Gender: □ Male □ Female □ Unspecified

Marital status: □ Single □ Married □ Other Spouse's Name: _____

Social security (if VA or auto accident): _____ - _____ - _____

Employment status: □ Employed □ FT Student □ PT Student □ Retired □ Self Employed

Occupation: _____

Race:

□ White □ Black/African American □Hispanic □American Indian/Alaskan Native

□ Asian □ Asian Indian □ Native Hawaiian or other Pacific Island □ I choose not to specify

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ I choose not to specify

Preferred Language: □ English □ Spanish □ American Sign Language □ Other: _____

Emergency contact information:

Full name: _____ Relationship: _____

Address: _____ Phone number: _____

City: _____ State: _____ Zip code: _____

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2. Patient Condition:

Reason for visit: □ Neck □ Upper back □ Low back □ Nutrition/weight loss □ Other: _____

Describe onset: □ Acute □ Chronic □ Gradual

Cause: □ Accident □ Unknown

Prior pain in this area? □ None □ On and off for years □ Years ago

Side: □ Left □ Right □ Both

CHANGES IN THIS CONDITION

Description: □ Improving □ Getting worse □ No change

Rate of change: □ Gradually □ Slowly □ Slight

Changed since: □ Last visit □ Treatment began □ Last month □ Last week □ _____

PAIN

Quality (check all that apply): □ Achy □ Burning □ Dull □ Sharp □ Stiff □ Throbbing

Description: □ Mild □ Moderate □ Severe

Range:

At best: No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

At its worst: No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

HOW OFTEN DOES THE PAIN OCCUR?

Description: □ Constant □ Intermittent

Does the pain radiate? □ Yes □ No If yes, explain: _____

When does it feel worse? □ No change □ Morning □ As day progresses □ Afternoon □ Evening □ During night

What exacerbates symptoms? □ Nothing □ Resting □ Sleeping □ Walking □ Working □ Movement

Feels better: □ No change □ Morning □ As day progresses □ Afternoon □ Evening □ During night

What alleviates symptoms? □ Cold □ Chiropractic care □ Massage □ Medication □ Movement □ Resting
□ Sleeping □ Walking □ Warmth

Is there any numbness? □ Yes □ No If yes, where: _____

Is there any spasms? □ Yes □ No If yes, where: _____

Is there any weakness? □ Yes □ No If yes, where: _____

Is there any swelling? □ Yes □ No If yes, where: _____

Is there any decreased range of motion? □ Yes □ No If yes, where: _____

Decreased range of motion: □ Mild □ Moderate □ Severe **Pain with movement**: □ Mild □ Moderate □ Severe

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Health Questionnaire

3. Allergies

Are you allergic to any medication(s)? □ Yes □ No If yes, which medications? _____

Are you allergic to any of the following?

□ Bee sting □ Latex □ Peanuts □ Shellfish □ Dairy □ Pollen □ Wheat

4. Social History

Do you currently smoke tobacco of any kind (cigarettes, electronic cigarettes, cigars, etc)?

□ Yes □ Former smoker □ Never been a smoker

If yes, how often do you smoke? □ Every day □ Occasional

If yes, what is your level of interest in quitting smoking? None 0 1 2 3 4 5 6 7 8 9 10 Interested

Do you currently drink alcohol? □ Yes □ No

If yes, how often do you consume alcohol? □ 1+ drinks daily □ 1-2 drinks a week □ 1-2 drinks a month

5. Medications

Current medications, including frequency and dosage if known. If no current medications, check here: □

	Medication Name	Quantity/Dosage	Frequency	Start Date
1				
2				
3				
4				

Do you currently use any recreational drugs? □ Yes □ No

6. Personal Health History

Are you currently under the care of a Healthcare Provider or any other doctor? □ Yes □ No
If yes, for what condition(s)?

_____

_____

Provider's Name: _____ Phone number: _____

Date of last:

Chiropractic Exam		Prostate/PSA	
MRI: _____		Mammogram	
Spinal x-ray: _____		Pap Smear	
CT-Scan:_____		Colon	
Bone Density Scan			

Immunizations: □ All recommended vaccines □ Not vaccinated

Surgeries:

	Date	Procedure
1		
2		

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Health Questionnaire

Illnesses:

□ ADD	□ CVA (stroke)	□ heart disease	□ Parkinson Disease
□ Alzheimer's	□ chicken pox	□ hepatitis	□ unsp. Pleual effusion
□ arthritis	□ cystic kidney dis.	□ HIV	□ psoriasis
□ asthma	□ depression	□ high blood pressure	□ psychiatric cond.
□ cancer	□ diabetes	□ pneumonia	□ scoliosis
□ cerebral palsy	□ eczema	□ liver disease	□ seizures
□ colitis	□ emphysema	□ lung disease	□ shingles
□ CRPS (RSD)	□ eye problems	□ lupus erythema	□ vertigo
□ STD's (unsp.)	□ fibromyalgia	□ multiple sclerosis	□ suicide attempt(s)
□ thyroid cond.	□ other: _____		

Injuries: (list date next to injury):

□ back injury	□ fracture	□ laceration (severe)
□ broken bones	□ head injury	□ motor vehicle accident
□ disability(ies)	□ industrial accident	□ soft tissue injury
□ fall (severe)	□ joint injury	□ other: _____

8. Family History

Relation	Age (now or at death)		Serious illness/cause of death
Father		□ Alive □ Deceased	
Paternal grandfather		□ Alive □ Deceased	
Paternal grandmother		□ Alive □ Deceased	
Mother		□ Alive □ Deceased	
Maternal grandfather		□ Alive □ Deceased	
Material grandmother		□ Alive □ Deceased	
Brother(s)		□ Alive □ Deceased	
Sister(s)		□ Alive □ Deceased	
Son(s)		□ Alive □ Deceased	
Daughter(s)		□ Alive □ Deceased	

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HEALTH CENTER

Health Questionnaire

7. Review of systems

Constitutional	□ None □ Chills	□ Drowsiness □ Fatigue	□ Fever □ Loss of appetite	□ Night sweats □ Weight gain/loss
Eyes/Vision	□ None □ Blindness □ Blind spots	□ Cataracts □ double vision □ eye problems	□ Itching □ photophobia □ tearing	□ Wears glasses/contacts
Ears Nose & Throat	□ None □ Dizziness □ ear discharge □ ear pain	□ fainting □ frequent sore throats □ headaches □ hearing loss	□ sinus infection □ loss of sense of smell □ nosebleeds □ nasal congestion	□ runny nose □ history of head injury
Respiration	□ None □ asthma	□ cough □ coughing up blood	□ shortness of breath □ sputum production	□ wheezing
Cardiovascular	□ None □ high blood pressure □ claudication (leg pain and ache)	□ heart problem □ low blood pressure □ orthopnea (difficulty breathing lying down)	□ palpitations □ shortness of breath with exertion □ ulcers	□ varicose veins □ paroxysmal nocturnal dyspnea □ heart murmur
Gastrointestinal	□ None □ abdominal pain □ abnormal stool	□ belching □ black/tarry stool □ constipation □ diarrhea	□ difficulty swallowing □ heartburn □ hemorrhoids □ indigestion	□ loss of bowel control □ ulcers □ rectal bleeding □ jaundice
Female	□ None/N/A □ abnormal bleeding	□ birth control □ breast lump/pain □ burning urination	□ frequent urination □ irregular menstruation □ hormone therapy	□ vaginal discharge □ urine retention/incontinence □ cramps
Male	□ None/N/A □ erectile dysfunction	□ burning urination □ hesitancy/ dribbling	□ frequent urination □ urine retention/incontinence	□ prostate problems
Skin	□ None □ change in nail texture	□ hair loss □ change in skin color □ hives	□ itching □ history of skin disorders □numbness	□ skin lesions/ulcers □ varicosities
Nervous system	□ None □ facial weakness □ dizziness □ headache	□ limb weakness □ loss of consciousness □ loss of memory □ numbness	□ seizures □ sleep disturbance □ slurred speech □ stress	□ stroke □ unsteadiness of gait/loss of balance
Psychological	□ None □ anxiety □ behavioral changes	□ bi-polar disorder □ confusion □ convulsions	□ depression □ insomnia □ loss or change of appetite	□ memory loss □ mood change
Hematologic	□ None □ anemia □ heart problem	□ bleeding □ blood clotting	□ blood transfusion □ bruising easily	□ fatigue □ lymph node swelling

Active Living
HEALTH CENTER

Health Questionnaire

All the answers I have given are correct to the best of my knowledge.

Patient signature: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____