Chiropractic Health Questionnaire

Conditions: Check conditions you have or have had in the past:

____ AIDS
____ Alcoholism
____ Anemia
____ Anorexia
____ Appendicitis
____ Arthritis
____ Asthma
____ Bleeding disorders
____ Breast lump
____ Bronchitis
____ Bulimia
____ Cancer
____ Cataracts
____ Chemical dependency
____ Chicken pox
____ Diabetes
____ Emphysema
____ Epilepsy
____ Fractures
____ Glaucoma
____ Goiter
____ Gonorrhea
____ Gout
____ Heart disease
____ Hepatitis
____ Hernia
____ Herpes
____ High cholesterol
____ HIV positive
____ Kidney disease
____ Liver Disease
____ Measles
____ Migraine headaches
____ Miscarriage
____ Mononucleosis
____ Multiple Sclerosis
____ Mumps
____ Osteoporosis
____ Pacemaker
____ Pneumonia
____ Polio
____ Prostate problems
____ Prosthesis
____ Psychiatric care
____ Rheumatoid Arthritis
____ Rheumatic Fever
____ Scarlet Fever
____ Stroke
____ Suicide attempt
____ Thyroid problems
____ Tonsillitis
____ Tuberculosis
____ Tumors, growths
____ Typhoid Fever
____ Ulcers
____ Vaginal infection
____ Venereal disease
____ Whooping Cough
____ Other_____
_____

General Symptoms: Check symptoms you currently have or have had in the past year:

GENERAL
____ Bruise easily
____ Chills
____ Dental problems
____ Depression
____ Difficulty sleeping
____ Dizziness
____ Fainting
____ Fever
____ Forgetfulness
____ Headache
____ Loss of sleep
____ Loss of weight
____ Nervousness
____ Numbness
____ Sweats
____ Tiredness
____ Weight gain

GENITO-URINARY
____ Blood in urine
____ Frequent urination
____ Lack of bladder control
____ Painful urination

GASTROINTESTINAL
____ Appetite, poor
____ Bloating
____ Bowel changes
____ Constipation
____ Diarrhea
____ Excessive hunger
____ Gas
____ Hemorrhoids
____ Indigestion
____ Nausea
____ Rectal bleeding
____ Stomach pain
____ Vomiting
____ Vomiting blood

CARDIOVASCULAR
____ Chest pain
____ High blood pressure
____ Irregular heartbeat
____ Low blood pressure
____ Poor circulation
____ Rapid heart beat
____ Swelling of ankles
____ Vericose veins

EYE/EAR/NOSE/THROAT
____ Bleeding gums
____ Blurred vision
____ Crossed eyes
____ Difficulty swallowing
____ Double vision
____ Earache
____ Ear discharge
____ Hay fever
____ Hoarseness
____ Loss of hearing
____ Nosebleeds
____ Persistent cough
____ Ringing in ears
____ Sinus problems
____ Vision-flashes
____ Vision-halos

SKIN
____ Bruise easily
____ Hives
____ Itching
____ Change in moles
____ Rash
____ Scars
____ Sores that won't heal

MEN ONLY
____ Breast lump
____ Erection difficulty
____ Lump in testicle
____ Penis discharge
____ Sore on penis
____ Other_____

WOMEN ONLY
____ Abnormal pap smear
____ Breast lump
____ Heavy periods
____ Hot flashes
____ Nipple discharge
____ Painful intercourse
____ Spotting
____ Vaginal discharge
____ Other_____
Date of last period_____
_____
Date of last pap smear__
_____
Date of mammogram___
_____
Are you pregnant?_____
Number of children____

Neck, back, extremities: Check symptoms you currently have or have had in the past year.

____ Neck
____ Shoulder pain ___L ___R
____ Mid back pain ___L ___R
____ Arms and hands ___L ___R
____ Low back
____ Hips, legs, feet ___L ___R

Please describe symptoms briefly:_____
_____
_____
_____
_____
Other symptoms:_____