Advanced Chiropractic Health Questionnaire

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____

Marital Status: ☐ Single ☐ Married Cell Phone: _____ Carrier: _____

Social Security #: _____ Primary Care Physician: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse's Name: _____ Spouse's DOB: _____ Spouse's SSN #: _____

Number of children/Names/Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Many patients are referred to our office by a family member or friend.
What or who made you decide to visit our office?

_____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: 1: _____
2: _____ 3: _____ 4: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

		How long have you had this condition?
Primary or chief complaint is	: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	_____months ____years
Second complaints is	: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	_____months ____years
Third complaint:	: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	_____months ____years
Fourth complaint:	: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	_____months ____years

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last?

☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen? _____

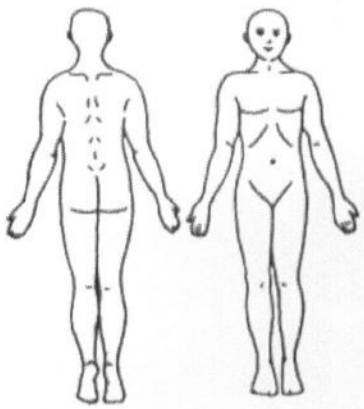
Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ Months/Years (circle) What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness
S = Sharp/ **S**tabbing **T= T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

Dr Renee Hurst 620-663-4100

Turn over →

Science tells us your spine should be cared for regularly. How often do you get adjusted by a chiropractor?
Frequently / Only when you hurt / 1 x monthly / Never

When was your last complete spinal examination including x-rays? _____ ☐ Never

Do you know if you have a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ Yes ☐ No

Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck?
☐ Yes ☐ No

If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back.
Do you often feel the need to crack or pop your neck or lower back? ☐ Yes ☐ No

Is your problem the result of any type of accident? ☐ Yes ☐ No

Do you have muscle spasms? ☐ Yes ☐ No

Have X-Rays/MRI/CT scans been done? ☐ Yes ☐ No

Have you had a nerve conductions study? ☐ Yes ☐ No

Do you have pain in your arms or legs? ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

Have you had injections or surgery for your condition? ☐ Yes ☐ No

Do you use medication to control pain or swelling? ☐ Yes ☐ No When did you start?_____

Do you use: (circle) cane brace wheelchair crutches other device to walk/sleep/sit?

Do you have back pain with: (circle) sitting standing driving for prolonged periods? ☐ Yes ☐ No

Have you lost... (circle) neck low back ...mobility with this injury? ☐ Yes ☐ No

Do you have (circle) bladder bowel sexual dysfunction with this injury? ☐ Yes ☐ No

Do you need assistance (circle) getting dressed getting out of bed with this injury? ☐ Yes ☐ No

Do you need assistance to perform daily living activities? ☐ Yes ☐ No
Please circle: Wash Brush Teeth Bath Shower Other

Do you need assistance with transportation? ☐ Yes ☐ No

Do you have (circle) muscle weakness, numbness, or loss of the use of an arm or leg? ☐ Yes ☐ No
Other problems not listed above: _____

Prescription medications cause various side effects hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (use back if necessary)
1._____ 2._____ 3._____

Allergies: _____

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PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____
When was the last episode? _____ How did the injury happen?_____

What other types of treatment have you tried? (circle) Physical Therapy Acupuncture Surgery Chiropractic
Massage Therapy Medication What helps you the most? _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past,*** **C** for ***Currently*** have and **N** for ***Never*** *have had*:
__ Broken Bone __Dislocations __ Tumors __Rheumatoid Arthritis __ Fracture __Disability
__Cancer __ Heart Attack __Osteo Arthritis __ Diabetes __Cerebral Vascular
__ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Advanced Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Advanced Chiropractic for any and all services I receive at this office.

_____ _____
Patient or Authorized Person's Signature Date Completed

_____ _____
Doctor's Signature Date Form Reviewed