YOUKER CHIROPRACTIC and MASSAGE

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CONFIDENTIAL HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____

1. Describe your chief complaints?_____

_____

2. When was the first time you noticed this problem?_____

How did it originally occur? _____

How are your symptoms changing? ____Getting Better ____Not Changing ____Getting Worse

3. How frequent is the condition? ____Constant ____Daily ____Intermittent ____Occasionally

How long does it last? ____All Day ____Few Hours ____Minutes

4. Describe the pain: ____Sharp ____Dull ____Aching ____Burning ____Stabbing

____Shooting/Radiating ____Numbness/Tingling ____Weakness

5. Indicate the *average* intensity of your symptoms: *None* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable*

6. Is there anything you can do to relieve the symptoms? Y / N If yes, describe: _____

_____

7. What makes the problem worse? ____Standing ____Sitting ____Lying ____Bending ____Lifting

____Twisting ____Reaching ____Walking ____Other_____

8. In general, would you say your overall health right now is….. ____Excellent ____Very Good ____Good

____Fair ____Poor

9. Are there any other conditions that you have that may be related to your chief complaints? Y / N
If yes, describe: _____

Are there any unrelated health problems? Y / N If yes, describe:_____
_____

10. Who else have you seen for your complaints? _____

What treatment did you receive and when? _____
_____

What tests have you had for your symptoms and when were they performed? _____
_____

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11. Have you had similar symptoms in the past? Y / N If yes, describe: _____
_____

12. Describe any pertinent prior trauma/accidents: _____
_____

13. Have you received previous chiropractic care? Y / N If yes,
Doctor's name and date of last treatment: _____

14. During the past 4 weeks:

a. How much have your symptoms interfered with your normal work *(including work outside the home, and housework)*? ____Not At All ____A Little Bit ____Moderately ____Quite A Bit ____Extremely

b. How much of the time has your condition interfered with your social activities *(like visiting friends/relatives, sports, etc.)*? ____Not At All ____A Little Bit ____Moderately ____Quite A Bit ____Extremely

15. Family Medical Doctor: _____ Phone: (___)_____

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

Date of last physical exam: _____

May we contact your M.D. if needed *(for reports, pertinent information, updating your care, etc.)*? Y / N

16. ***WOMEN ONLY:*** Are you pregnant, or is there any possibility you may be pregnant? Y / N
If yes, what is your delivery date? _____

Do you have breast implants? Y / N

The statements made on this form are accurate to the best of my knowledge, and I agree to allow *YOUKER CHIROPRACTIC and MASSAGE* to examine me for further evaluation.

Signature: _____ Date: _____
(Patient, Parent, Legal Guardian)

(OFFICE USE ONLY)

Doctors Notes: _____
_____
_____
_____
_____
_____
_____
_____