WALKER ROAD CHIROPRACTIC
Chiropractic, Rehab & Massage

Initial Health Questionnaire

Patient's name: _____ **Date**: _____

How would you rate you pain today?

None		*Annoying*		*Uncomfortable*		*Dreadful*		*Horrible*		*Agonizing*
0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***

No Distress *Unbearable Distress*

Please indicate on the figures below what and where your present complaints are

Key

P – Pain

St – Stiffness

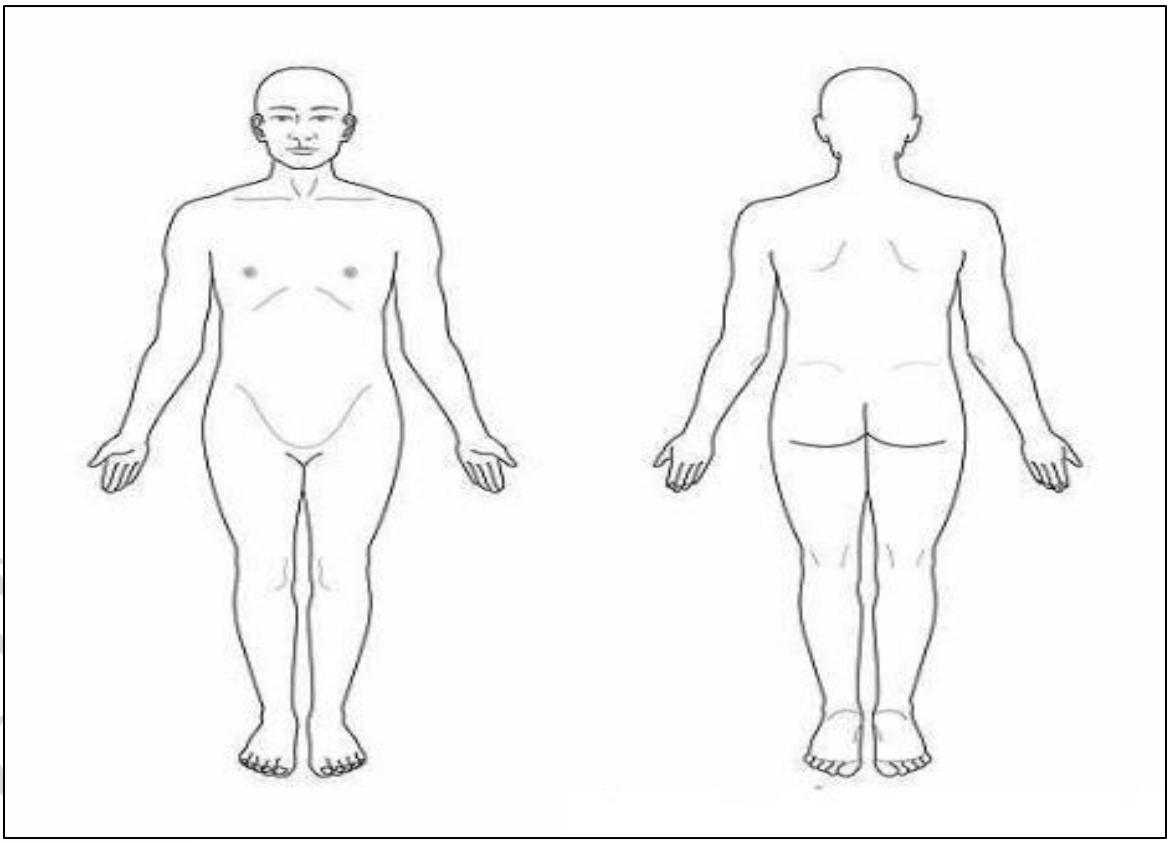
Sw – Swelling

N – Numbness

T – Tingling

B – Burning

W – Weakness



How did these complaints begin?

□ Suddenly
□ Gradually
□ Unknown

On what date did these complaints begin?

□ Neck/Back ____/____/_____ □ Upper Extremities ____/____/_____ □ Lower Extremities___/____/_____

What happened to cause or re-aggravate your complaints?

□ Work Accident/Injury □ Personal Injury □ Auto Accident □ Home Accident
□ Sports Injury □ Cause Unknown □ Other (please describe) _____

_____

_____

When are your symptoms worse?

□ Morning □ Afternoon □ Evening □ Night □ Always the Same

What makes your condition better?

□ Nothing □ Rest □ Sitting □ Standing □ Stretching □ Exercise □ Heat □ Ice
□ Medications □ Other (please describe)_____

_____

What makes your condition worse?

□ Nothing □ Coughing □ Sneezing □ Reaching □ Standing □ Bending
□ Pulling □ Turning □ Walking □ Sitting □ Straining at stool □ Lifting
□ Other (please Describe): _____

Have any of your complaints existed in the past? □ Yes *If" yes", indicate below* □ No

□ Neck □ Upper Back □ Mid Back □ Low Back □ Ribs □ Shoulders □ Arm
□ Elbow □ Forearm □ Wrist □ Hand/Fingers □ Buttock □ Hip □ Thigh
□ Leg/Calf □ Ankle □ Foot □ Other (please describe)_____

Since your symptoms began have you noticed a change in…?

□ Bowel Function □ Bladder function □ Sexual Function □ No Change in Functions

Have you had any recent treatments for your condition OUTSIDE of this office? □ Ye □ No

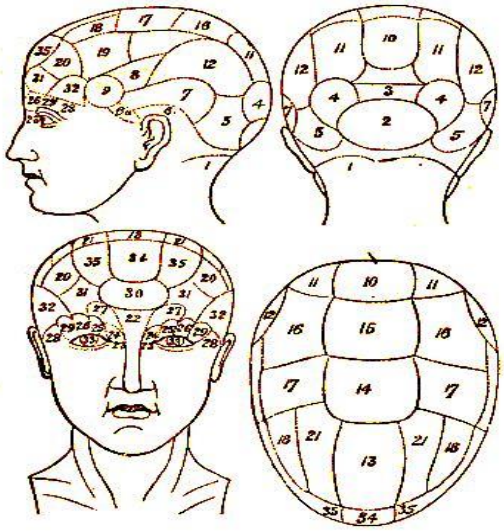
Date	*Treatments*	*Doctor*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Comments:_____
_____
_____

Headaches

(if you experience headaches please fill out this section, if not you may skip this section)

Pease indicate on the figure where the pain associated with your headache is located.



On what date did your headaches start?

□ Date ____/____/_____ □ Unknown

Do any of the following symptoms occur with your headaches?

□ Nausea/Vomiting □ Weakness
□ Vision Problems □ Tremors
□ Light/Sound sensitivity □ Dizziness
□ Other:_____
_____

How does the intensity of your headache usually rate?

No pain 1 2 3 4 5 6 7 8 9 10 Worst pain possible

How often do they occur?

Times/Week 1 2 3 4 5 6 7 8 9 10+
Times/Month 1 2 3 4 5 6 7 8 9 10+
□ Other:_____

How long do your headaches usually last?

□ Less Than 1 Hour □ 1-3 Hours □ 3 Hours +
□ All Waking Hours □ Several Hours to Days
□ Other:_____

When do your headaches usually start?

□ Constant/Anytime Awake □ Wake Up With In Morning
□ At Midday □ During Evening

What describes the type of pain you experience?

□ Dull □ Sharp □ Aching □ Stabbing
□ Deep □ Vice-Like □ Burning □ Throbbing/Pulsation

What seems to bring your headaches on?

□ Physical Activity □ Caffeine □ Excessive Stress
□ Certain Foods □ Alcohol □ Menstrual Period
□ Other:_____

What makes your headaches better?

□ Nothing □ Rest □ Lying Down □ Ice/Cold Pack
□ Massage □ Standing □ NSAIDS (*tylenol, asprin, etc.*)
□ Other:_____

Do your headaches ever wake you from sleep?

□No □ Sometimes □ Always

Health History

Review of symptoms: Are you currently suffering from any of the symptoms / conditions listed below

General Fatigue		Mouth Sores		Heart Palpitations	
Weakness		Bleeding Gums		Heart Murmur	
Fever (continuous)		Enlarged Gums		Painful Urination	
Loss of Sleep		Absence of Taste		Inability to Hold Urine	
Night Sweats		Abnormal Taste Sensation		Frequent Urination	
Headaches		Infected Tonsils		Urinary Retention	
Dizziness		Difficulty Swallowing		Bed-wetting	
Fainting		Heat/Cold Intolerance		Irregular Menstruation	
Convulsions		Sugar in Urine		Painful Menstruation	
Nervousness		Goiter (enlarged Thyroid)		Abnormal vaginal Bleeding	
Anxiety		Tremors (shaking)		Sterility	
Depression (prolonged)		Skin Rash		Impotence	
Phobias (excessive fears)		Redness of skin		Lumps in Breast(s)	
Memory Loss/impairment		Skin Itching		Redness/Itching of Breasts	
Mood Swings		Skin Dryness		Dimpling of Breast(s)	
Hearing Trouble		Eczema (red, inflamed skin)		Discharge from Breast(s)	
Ringing in the Ears		Hair Change (unplanned)		Breast Pain	
Pain in the Ears		Nail change (unplanned)			
Ear Discharge		Bruise Easily		Other: (Please Describe)	
Vision Trouble		Cough (chronic)			
Pain in the Eyes		Wheezing (chronic)			
Eye Discharge		Difficulty Breathing			
Nose/Sinus Pain		Swollen Extremities			
Excessive Drainage		Blue Extremities			
Nose Bleeds (chronic)		Varicosities (visible veins)			
Nose Infections (chronic)		Rapid Heart Beat			
Absence of Smell		Chest Pain		**None of the symptoms listed**	

Habits / Activities

What are your current habits?

						Packs Per Day		
Smoking	□ Yes	□ No	*If "yes" how many*	□ 1	□ 2	□ 3	□ 4	□ 5+
						Cups Per Day		
Caffeinated Drinks	□ Yes	□ No	*If "yes" how many*	□ 1	□ 2	□ 3	□ 4	□ 5+
						Glasses Per Day		
Alcohol Consumption	□ Yes	□ No	*If "yes" how many*	□ 1	□ 2	□ 3	□ 4	□ 5+
Drugs/Substance Abuse	□ Yes	□ No						

			Days Per Week		
Exercise	□ Never	□ Less than 1	□ 1-2	□ 3-4	□5+

What Kinds of exercise do you do?

□ Jogging □ Cycling □ Golf □Tennis □ Swimming □ Weight Lifting □ Thai Chi

□ Walking □Yoga □ Pilates □ Strength / Conditioning Other: _____

_____

Does exercising seem to aggravate your current complaints? □ Yes □ No

Medical History

Have you ever been to a chiropractor before? □ Yes □ No

Do you have a family physician?

Date of last physical exam: _____ Physician's name: _____

Address: _____ Phone: _____ Ext. (_____)

Have you ever been hospitalized in the past? □ Yes □ No

Dates	*Reason for hospitalization*
_____	_____
_____	_____
_____	_____

Have you ever had surgery? □ Yes □ No

Dates	*Reason for surgery*	*Result*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a serious accident/injury? □ Yes □ No

Please list and describe

Auto: _____ Work – Related: _____

Sports Injury:_____ Personal Injury:_____

Other: _____

Are you currently taking any vitamins, minerals or herbs? □ Yes □ No

Please list them

_____ _____ _____

_____ _____ _____

Are you currently taking any medications (*prescription or OTC*)? □ Yes □ No

Please list the name of the medication and what condition you are taking it for

_____ _____ _____

_____ _____ _____

In the past have you ever used the following □ Birth Control Pills □ Corticosteroids

Are you allergic to any medications? □ Yes □ No

Please list them

_____ _____ _____

_____ _____ _____

(Women only)

To The best of your knowledge, are you pregnant? □ Yes □ No

If pregnant in past, were pregnancies normal? □ Yes □ No

Are you seeing an OB-GYN regularly? □ Yes □ No

Number of births? □ 1 □ 2 □ 3 □ 4 □ 5 □ Other _____ **Date of last exam**: _____

Physician's name: _____ **Phone**: (_____)____--_____ext(____)

Family History

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Kidney Disease	Mental Illness	Osteoporosis	Arthritis	Joint Problems	Back Problems	Genetic Disease	Deceased
Father	□	□	□	□	□	□	□	□	□	□	□	□	□
Mother	□	□	□	□	□	□	□	□	□	□	□	□	□
Brothers	□	□	□	□	□	□	□	□	□	□	□	□	
Sisters	□	□	□	□	□	□	□	□	□	□	□	□	
Children	□	□	□	□	□	□	□	□	□	□	□	□	

Conditions or Illnesses: Please indicate if you **have** or **have had in the past**, any of the following illnesses.

Have Now	Had in Past		Have Now	Had in Past		Have Now	Had in Past	
		Sinus Troubles			Heart Trouble			Scoliosis
		Hay Fever			Pacemaker			Dislocated Joints
		Allergies			Stroke (date_____)			Spinal Disc Disease
		Asthma			Aortic Aneurysm			Bone Fracture(date(s)_____
		Emphysema			Anemia			_____)
		Tuberculosis			Rheumatic Fever			Mental / Emotional Difficulty
		History of Infections			Polio			Sexually Transmitted Diseases
		Fever (Continuous)			Multiple Sclerosis (MS)			HIV
		Cancer / Tumor			Ulcer			AIDS / ARC
		Diabetes			Liver Trouble			Abnormal Weight Gain
		Visual Disturbances			Kidney Trouble			Abnormal Weight Loss
		Dizziness / Fainting			Urinary Retention			Numbness in Groin / Buttocks
		Epilepsy / Seizures			Frequent Urination			Other:
		Thyroid Troubles			Prostate Trouble			
		High Blood Pressure			Arthritis			Other:
		Low Blood Pressure			Osteoporosis			

Occupational Information/Activities of Daily Living

Are you right or left handed? □ **Right** □ **Left**

What is your job type? □ Full-Time □ Part-Time □ Temporary □ Self-Employed

□ Retired □ Unemployed □ Full-Time Student
If any of the above skip rest and sign at "Patient's Signature"

□ Other:_____

During your work week, you work how many:

Hours Per Day? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10+

Days Per Week? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

How long have you been at your present employer?

Years □ 10 □ 20 □ 30 □ 40 □ 50

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9

Months □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11

What is your primary working position? □ Seated □ Standing □ Other_____

What is your primary working location? □ Desk □ Counter □ Workbench
□ Other_____

What Movements does your job require? □ Bending □ Twisting □ Turning □ Stooping
□ Repetitive Hand Use □ Walking □ Carrying □ Other: _____

Does your job require the following? □ Prolonged Computer Use □ Continuous Phone Use

Does your job ever require lifting? □ Never □ Occasionally □ Intermittently □ Frequently

How Many Pounds? _____ lbs. **What is your stress level at work?** _____

What is your activity level at work? □ Seated >50% of time □ Light □ Moderate □ Heavy

Do work activities aggravate your present complaints? □ Yes □ No *If "yes" Explain*: _____

_____

_____

Patient's signature (or Guardian if minor): _____ **Date**: _____