Health History Questionnaire

The Back Pain Relief & Wellness Center
Keezer Chiropractic
3701 Colby Avenue Everett, WA 98201
425-259-3700

Date:_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**	**Age:**
Address:		**Apt or Unit #:**	
City, State, Zip:		**SSN:**	
Home Phone: OK to leave Message?		**Cell Phone:** OK to leave Message?	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Spouse's/Significant Other's Name:			
Number of Children:	**Names & Ages of Children**:		
Occupation:		**Employer:**	
Work Phone:		**May we contact you at work?** ☐ Yes ☐ No	
Emergency Contact Name & Relation:		**Phone:**	
Your Email:			
Who can we thank for referring you?		**If not referred, how did you find us?**	

PERSONAL HEALTH HISTORY

What is your major complaint?			
Is this condition related to an injury or sickness that is work or auto-accident related? ☐ Yes ☐ No	If Yes, Date: (Please see receptionist if you answer yes)	Time:	Place:
If this is not due to a recent accident, when did symptoms appear?			
What were you doing when symptoms appeared?			
Have you ever had a similar condition?		**When?:**	
Please describe:			
Previous or referring doctor:		**Date of last physical exam:**	
Have you lost days from work? ☐ Yes ☐ No	**How Many?**	**Does the condition interfere with your:**	☐ Work ☐ Sleep ☐ Daily Routine ☐ Other_____
Is the condition getting worse?: ☐ Yes ☐ No ☐ Constant ☐ Comes and goes			
How long has it been since you felt good?		**What do you believe is wrong with you?:**	
Have you seen other doctors for this condition?		**If yes, what specialty?**	
Have you been in a doctor's care in the past year?? ☐ Yes ☐ No		**What for?**	
Have you been under chiropractic care?: ☐ Yes ☐ No		**Doctor's Name?**	
When was your last treatment?		**Results?**	

List any medical problems or serious illnesses that other doctors have diagnosed

Surgeries or Hospitalizations

Year	Reason	Hospital

Place patient label here

Have you ever had a blood transfusion?	☐ Yes ☐ No

List your prescribed drugs, over-the-counter drugs, vitamins and inhalers (including supplements)		
Name of the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	Do you get 7-13 ½ cup servings of fruits and vegetables daily?				☐ Yes	☐ No
	If no, would you like to find out how to get more fruits and vegetables in your diet?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No

Place patient label here

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

HEAD

☐ Headache
- ☐ Sinus (allergy)
- ☐ Entire head
- ☐ Back of head
- ☐ Forehead
- ☐ Temples
- ☐ Migraine

☐ Head feels heavy
☐ Loss of memory
☐ Light-headedness
☐ Fainting
☐ Light bothers eyes
☐ Blurred vision
☐ Double vision
☐ Loss of smell
☐ Loss of taste
☐ Dizziness
☐ Loss of hearing
☐ Pain in ears
☐ Ringing in ears
☐ Buzzing in ears

ARMS & HANDS

☐ Pain in upper arm
☐ Pain in elbow
☐ Movement aggravated
☐ Tennis elbow
☐ Pain in forearm
☐ Pain in hands
☐ Pain in fingers
☐ Sensation of pins/needles in arms
☐ Sensation of pins/needles in fingers
☐Numbness in arms (R or L)
☐ Numbness in fingers (R or L)
☐ Fingers go to sleep
☐ Hands cold
☐ Swollen joints in fingers
☐ Sore joints in fingers
☐ Arthritis in fingers
☐ Loss of grip strength

LOW BACK

☐ Low back pain
- ☐ Upper lumbar
- ☐ Lower lumbar
- ☐ Sacro-iliac

☐ Low back pain is worse when:
- ☐ working
- ☐ lifting
- ☐ stooping
- ☐ standing
- ☐ sitting
- ☐ bending
- ☐ coughing
- ☐ lying down (sleeping)
- ☐ walking

☐ Pain is relieved when: _____
☐ Slipped disc
☐ Low back feels out of place
☐ Muscles spasms
☐ Arthritis

NECK

☐ Pain in neck
☐ Neck pain with movement:
- ☐ Forward
- ☐ Backward
- ☐ Turn to left
- ☐ Turn to right
- ☐ Bend to left
- ☐ Bend to right

☐ Pinched nerve in neck
☐ Muscle spasms in neck
☐ Grinding sounds in neck
☐ Grading sounds in neck
☐ Popping sounds in neck
☐ Arthritis in neck

MID-BACK

☐ Mid-back pain
Location: _____
☐ Pain between shoulder blades
☐ Sharp stabbing
☐ Dull ache
☐ Pain from front to back
☐ Muscle spasms
☐ Pain in kidney area

CHEST

☐ Chest Pain
☐ Shortness of breath
☐ Pain around ribs
☐ Breast pain
☐ Dimpled or orange peel breast
☐ Irregular heartbeat

HIPS, LEGS & FEET

☐ Pain in buttocks (R or L)
☐ Pain in hip joint (R or L)
☐ Pain down leg (R or L)
☐ Pain down both legs
☐ Knee pain (R or L)
- ☐ inside
- ☐ outside

☐ Leg cramps
☐ Cramps in feet (R or L)
☐ Numbness of feet (R – L)
☐ Numbness of toes
☐ Feet feel cold
☐ Swollen ankles (R – L)
☐ Swollen feet (R – L)

SHOULDERS

☐ Pain in shoulder joint (R or L)
☐ Pain across shoulders
☐ Bursitis (R or L)
☐ Arthritis (R or L)
☐ Unable to raise arm
- ☐ Above shoulders
- ☐ over head

☐ Tension in shoulders
☐ Pinched nerve in shoulder (R or L)
☐ Muscle spasms in shoulders

GENERAL

☐ Nervousness
☐ Irritable
☐ Depressed
☐ Fatigue
☐ Generally feel run-down
☐ Normal Sleep _____ hours
☐ Loss of weight _____ lbs
☐ Gain weight _____ lbs
☐ Diabetes
☐ Hypoglycemia

ABDOMEN

☐ Nervous stomach
☐ Foods can't eat:_____
☐ Nausea
☐ Gas
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids

WOMEN ONLY

☐ Menstrual Pain
☐ Cramping
☐ Irregularity
☐ Cycle is _____ days
☐ Birth Control:_____ (type)
☐ Hysterectomy
☐ Genital Cancer: _____
☐ Abnormal Discharge

MEN ONLY

☐ Urinary Frequency
☐ Difficulty in starting
☐ Dribbling
☐ Night urination
☐ Prostate pain/swelling

Place patient label here