Health Questionnaire

Please answer all questions to the best of your knowledge, complete and accurate information helps us to provide you with the best possible care.

Name:____ **Nickname:**___________
First initial Last Suffix

Address: ____
Street Apt# City State Zip

Home Phone: ____________________ **Work/Alternate Phone:**_________________

E-Mail: ___________________________ **Employer:**_________________________

Social Security #_________________ **Date of Birth:** ____________ **Gender: M / F**

Marital Status: ___S __ M ___ D ___ W **Spouse's Name:** ______________

If your insurance is through your spouse, parent or guardian, please provide their employer _________________________________ **and Date of Birth**____________

How did you hear about our office?____

Is this a Work related Injury? ________ **Did you have an automobile accident?** ______

What is your height and weight: **Height** __________ **Weight**____________

Frequency of exercise: ___Never ___Rarely ___Occasionally ___ Moderately __ Regularly

Intensity of Exercise: ___Low Level ___Medium Level ___ Occasionally ___ High Level

Sufficient Rest: ____ Never ____Rarely ___ Occasionally _____ Moderately

Hours of Sleep: _________

Well Balanced Diet: _____Never ____Rarely ____Occasionally _____ Moderately

Do you smoke? ____NO ____Occasionally ____ less than 1 pack per day
1 to 2 _____ 2 to 3 _______ 4 to 5 _____ ____ More than 5 packs/day

Do you drink caffeinated beverages? _____NO ______ Occasionally ____ 1 to 2
____2 to 3 _____ 3 to 4 ____4 to 5 ____ More than 5 drinks/ day

Do you drink alcoholic beverages? ____No ____ Occasionally ____ 1 to 2
____2 to 3 _____ 3 to 4 ____4 to 5 ____ More than 5 drinks/ day

Have you ever used street drugs? _________Yes ______No

Doctor signature____

Please answer the following questions regarding your work related injury:

Date of injury:_____________________ Time injury occurred:____________

In what County did the injury occur?__________________

Employer at the time of accident:__________________ Phone #__________________

Employer's address: ____

Type of business________________________________

On the date of injury, what was your job title:___________________

On the date of injury what were your usual work activities: ________________________

____

How did the injury occur? ____

____

____

The injury was reported to_______________ ☐ orally ☐ in writing, on ____________

Are you currently working? ☐ Yes ☐ No If yes, current employer _______________

Are you working ☐ Full Duty ☐ Light Duty AND ☐ Full Time ☐ Part Time

If no, provide date last worked ____________AND doctor who took you out of work

If you are not working, but for reason not related to this worker's compensation case

Please explain ____

CARRIER INFORMATION:

Workers compensation carrier name: ____

Address:____

____

____

Phone # (if known)_____________________ Fax #(if known) ____________________

WCB case # __________________________________ (if known)

Carrier case #__________________________________(if known)

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Signature:____ **Date**________________

NAME:__________________________ **DATE** ____/____/______ **Account#:**____________

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and it's location: ____________________________

What caused the onset?: ____________________________

Date of onset?: _____/_____/_______

TIMING AND DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent _____Occasional

SEVERITY

On a scale of 0 to 10, with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to severe 7 = Mildly severe, restricts some activity 8 = Severe, limits most activity
9 = Very severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

How would you rate your pain on a good day on a scale of 0 to 10?
____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

How would you rate your pain on a bad day on a scale of 0 to 10?
____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____Inflexibility ____Stiffness ____Spasms ____Cramps

Other: ____________________________

QUALITY

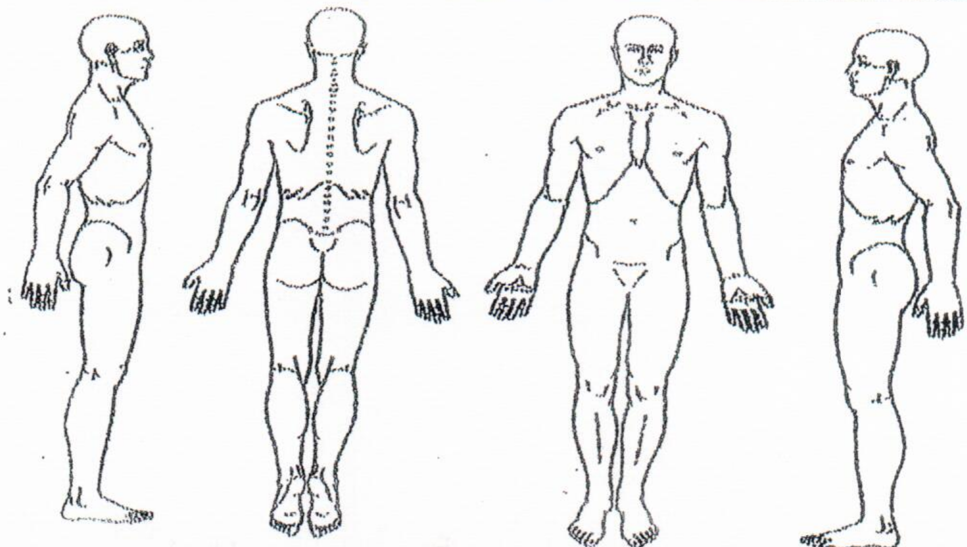
How would you best describe the sensation of the pain/symptom:

____Deadness ____Stabbing ____Burning ____Dull
____Prickly ____Hurting ____Shooting ____Sharp
____Numb ____Pulsating ____Throbbing ____Aching
____Crawling ____Pins & Needles ____Stinging ____Excruciating
____Tingling ____Pounding

ADDITIONAL ASSOCIATED SIGNS & SYMPTOMS

If this pain/symptom radiates or travels, please identify where to: ____________________________

Please mark where you have pain or other symptoms on the chart



Doctor Signature ____________________________

Name:________________________________ Date: _____/_____/_____ Account#__________

Modifying factors

What aggravates the pain and symptoms?

_____Flashing lights _____Sneezing _____Lifting _____Exercising

_____Stress _____Carrying _____Pushing _____Pulling

_____Coughing _____Sitting _____Stooping _____Looking side/side

_____Looking up/down _____Standing _____Walking _____Climbing stairs

_____Getting out of Bed _____Driving _____Laying down _____Straining at BM

_____Getting in/out of car _____Depression _____Walking up hill / over uneven terrain

Other: ____

What relieves the pain and symptoms?

_____Resting _____Sleeping _____Cold _____Heat _____Sitting

_____Shower _____Mineral Ice _____Advil _____Aspirin _____Tylenol

______Pain pills _____Exercise/Movement Other: ______________________

Who have you seen for your symptoms: _______Medical Doctor _______ Other Chiropractor

_______ Physical Therapist ______No One

OTHER: ________________

When and what type of treatment ________________________________

Over the past weeks/months your pain and symptoms are:

_____Improving ____Getting Worse _____About the Same

What tests have you have for your symptoms?

MRI: date: __________ CAT scan date: __________ X-rays: date: _________

Other: _____________date:________

Have you had similar symptoms in the past? Y N if yes when? ____________________

Have you ever been in a car accident or had any other work related injuries? ____Yes ____No

If yes, please give date(s) and accident type:________________________________

and provide a brief explanation of your injuries:

____

____

____

Name:________________________________ Date: ____/_____/_____ Account#__________

Medical History:

Have you ever been diagnosed with or suffered from:

____Aids ____Cancer ____Epilepsy ____Multiple Sclerosis ____Tuberculosis

____Anemia ____Diabetes ____Asthma ____Depression ____Alcoholism

____Stroke ____Foot Problems _____Gout _____High Cholesterol

____Heart Disease ____Heart Attack ____Chronic Sinusitis

Have you ever: When?

Been knocked unconscious? Y N ____________

Used a Crutch or other support? Y N ____________

Been treated for a spine or nerve disorder Y N ____________

Had a fractured bone? Y N ____________

Are you Pregnant? ___Yes ___No Do you think you may be pregnant? ____Yes ____No

Are you now or have you ever taken birth control pills? Y N Year __________

Are you now or have ever been on Hormone replacement therapy? Y N Year _______

Do You Have a Pacemaker? _____Yes ______No

Please list all surgical procedures you have had and times you have been hospitalized (besides Pregnancy):____

____

____

Please list all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:____

____

____

This Patient History was obtained from:

_____Patient ____Mother _____Father ____Son ____Daughter Other: __________

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Signature: ________________________________ Date:________________

Doctor Signature: ________________________