PUFFIN CHIROPRACTIC

FAITH FAMILY WELLNESS

Puffin Chiropractic Health Questionnaire

Patient Information

Date of Visit: _____ **How did you hear about us?** _____

Patient Legal Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Phone number: _____ Mailing Address: _____

List all prescription, non prescription medications and other vitamin/supplements:

_____
_____
_____
_____
_____
_____

List any surgeries or hospitalizations you have **ever** had (month-- year) for each: *(Children, LOC, Fx, MVA, Sport)*

_____
_____
_____
_____
_____

List anything you are allergic to:

_____
_____
_____

Family (Biological) History: list **ALL** major diseases such as cancer, diabetes, heart problems, bone/joint diseases and their relation to you. Has anyone in your family **passed away before age 50**? Have brain/mental disease?:

_____
_____
_____
_____
_____
_____
_____

What is your occupation?_____

Do you exercise? □ Yes □ No Hours per week What activity(s)?

_____

_____

_____

Are you dieting? □ Yes □ No Since: Do you smoke? □ Yes □ No □ Former _____ packs per day.

How many years have you been smoking? Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heel lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks?

_____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

_____

_____

_____

Are you here because of an accident?_____ If yes, What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

_____

How often do you experience symptoms? **(Circle one)** Constantly Frequently Occasionally Intermittently

Describe your symptoms? **(circle all that apply)** Sharp Dull/Ache Numb Burn Tingle Shooting Other

Are your symptoms? **(Circle one)** Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?

_____

_____

_____

What position do you sleep at night? **(circle all that apply)** Stomach Back Right Side Left Side

Have you experienced these same/similar symptoms in the past?

_____

_____

_____

Are you having problems with bowel or bladder? _____ Have you had fever/infection in the past 2 weeks? _____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? Yes No If yes, When was your last Adjustment? _____

Did they/have you ever taken spinal X-rays? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

_____

_____

_____

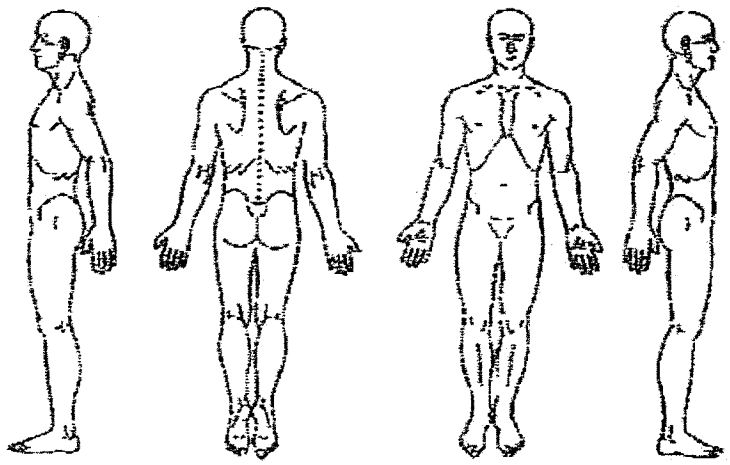
_____

Description of Condition

"On a 0 to 10 scale"

(0 is no pain, 10 is Emergency Room); **What is your worst?_____, Average?_____, Best?_____**
Mark any/all area(s) of discomfort on the body below:

A =Ache **N** =Numbness **B** = Burning **T** = Tingling **S** = Stiffness **O** = Other
Left Side Left | Right Right | Left Right Side



Left Back Front Right

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition. (Review of Systems)

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
o	o	Abnormal Weight Gain/Loss	o	o	Liver/Gallbladder Disorder	o	o	Angina/Chest Pain
o	o	Abdominal Pain	o	o	Epilepsy/Seizures	o	o	Neck pain
o	o	Migraines/Headache	o	o	Excessive thirst	o	o	Jaw/TMJ pain
o	o	Glasses/Eye Problems	o	o	Frequent Urination	o	o	Upper back pain
o	o	Dental/ Hearing problems	o	o	HIV/AIDS	o	o	Mid back pain
o	o	Arthritis/Osteoporosis	o	o	High blood pressure	o	o	Low back pain
o	o	Asthma / Sleep Apnea	o	o	Heart attack	o	o	Hip/upper leg pain
o	o	Bladder Infections/ UTI recurrent	o	o	Systemic Lupus/ Auto-Immune	o	o	Knee/lower leg pain
o	o	Birth Control Pills	o	o	Hepatitis	o	o	Ankle/foot pain
o	o	Cancer	o	o	Tumor/Cysts	o	o	Wrist/Hand pain
o	o	Loss of Bowel/ Bladder Control	o	o	General/Excessive Fatigue	o	o	Elbow/upper arm pain
o	o	Chronic Sinusitis	o	o	Hormone Therapy/ Steroids	o	o	Shoulder pain
o	o	Smoking/tobacco Use	o	o	Joint swelling/ stiffness/Hardware	o	o	Thoracic Outlet Syndrome
o	o	Dermatitis/Eczema	o	o	Ulcer/Hernia	o	o	Painful Urination
o	o	Depression	o	o	Kidney Stones	o	o	Dizziness/Vertigo
o	o	Drug/Alcohol Abuse	o	o	Prostate Problems	o	o	Stroke

***Emergency Contact:** Name: _____ #:_____ Relationship:_____

Additional comments you would like the doctor to know: _____

_____

_____

Patient's/Guardian signature: _____ **Doctor's signature:** _____

Printed Relationship if Guardian: _____ **Date:**_____

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