

Health Questionnaire

Patient #	_____
Today's Date	_____

Patient Information

Name	_____
Address	_____

Home Phone	_____
Cell Phone	_____
Work Phone	_____
Social Security	_____
Drivers License #	_____
Date of Birth	_____
Age	_____
Sex	_____
Marital Status	_____
E-mail	_____
Spouse Name	_____
Spouse DOB	_____
Spouse SS#	_____
Emergency Contact:	_____
Ph#:	_____

Occupational Information

Occupation:	_____
Employer:	_____
Address:	_____
Does your job require any of the following: If yes, please explain.	
excessive lifting	_____ Pounds _____
excessive sitting	_____ Hours _____
excessive bending	_____
excessive stooping	_____
excessive standing	_____
Has your current condition: required you to miss work? _____ If yes, explain	
effected your job requirements? _____ If yes, explain	
effected any daily activities? _____ If yes, explain	

Primary Complaint

Describe your primary complaint	_____

Cause of pain or injury:	_____
Is your injury in any way related to:	auto accident _____ work or job _____
Date of Injury/Symptoms:	_____
Describe your symptoms:	_____
Are your symptoms	getting better _____ getting worse _____ same _____ unsure _____
Does anything make your symptoms better? If yes, please explain:	_____
Have you seen any of the following for your current condition:	Chiropractor _____ M.D. _____ D.O. _____ other _____
If yes to any, please explain:	_____
Have you ever had any massage therapy? Y / N	When? _____
What type of massage?	_____
Have you ever experienced the same or similar symptoms? If yes, please explain:	_____
List any family medical history you are aware of:	_____
Medications you are currently taking:	_____

Health Questionnaire

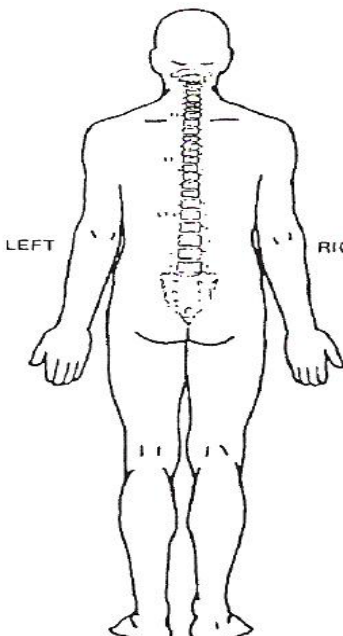
Patient # _____
Today's Date _____

Secondary Complaints

List any other areas of complaint that you would like us to address: _____

Please explain any injuries associated with these areas. _____

Mark all Complaints Primary and Secondary



SEVERITY OF PAIN
 List region of pain and circle severity number. [1 = least, 10 = greatest]

ex. Neck
 1 2 3 (4) 5 6 7 8 9 10

MARK PAIN AREA
 +++ Burning
 000 Stabbing
 --- Sharp
 III Constant

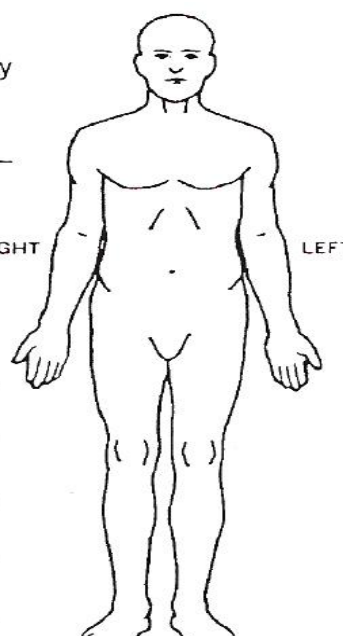
1. _____
 1 2 3 4 5 6 7 8 9 10

2. _____
 1 2 3 4 5 6 7 8 9 10

3. _____
 1 2 3 4 5 6 7 8 9 10

4. _____
 1 2 3 4 5 6 7 8 9 10

5. _____
 1 2 3 4 5 6 7 8 9 10



Please mark area of pain on the drawing using the code listed above.

Informed Consent

I certify that the above information is truthful to my knowledge and I have no pre-existing condition that I have not disclosed in the above questionnaire. By signing below, I give my consent to be treated by the doctors and staff associated with Green Oaks Chiropractic Clinic and/or Horizon Chiropractic and Wellness Center.

Signature of Patient _____

Date _____

Patient Name Printed _____

Parents' Signature _____

How were you referred to our office? _____