

Aldrich Chiropractic Center, LLC Health History Questionnaire

Patient Name: _____

Date: _____

1. Describe your symptoms: _____

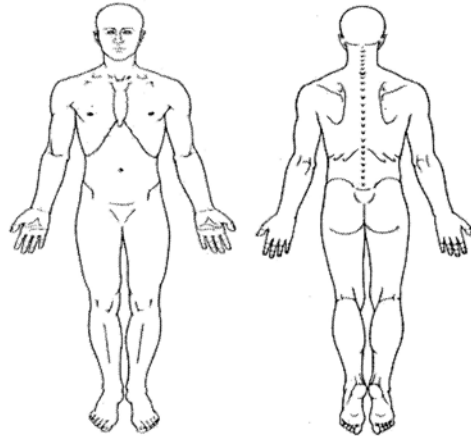
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms.



3. What describes the nature of your symptoms?

- Sharp Shooting
- Dull Ache Burning
- Numbness Tingling

4. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

5. Describe your pain level:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
No Pain Very Painful

6. Who else have you seen for your symptoms? _____

a. What diagnosis were you given? _____

7. Is this your first visit to a Chiropractic Physician? Yes No

Date of last Chiropractic visit: _____

a. How long has it been since you had spinal x-rays? _____ Area of x-ray: _____

For each of the conditions below place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Middle Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Arms	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Light Headed
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Legs	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C
<input type="checkbox"/>	<input type="checkbox"/>	Foot/Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Pre-menstrual Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss/Gain
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

8. List all surgical procedures you have had and the times you have been hospitalized _____

9. List all prescription, over the counter medications, and nutritional/herbal supplements you are taking _____

10. For our Female patients: Are you currently Pregnant? YES NO MAYBE

If yes, how far along are you? _____ Last Menstrual Cycle began on _____

Patient Signature _____

Date _____