Aldrich Chiropractic Center, LLC Health History Questionnaire

Patient Name:_____Date:_____

1. Describe your symptoms:_____

_____

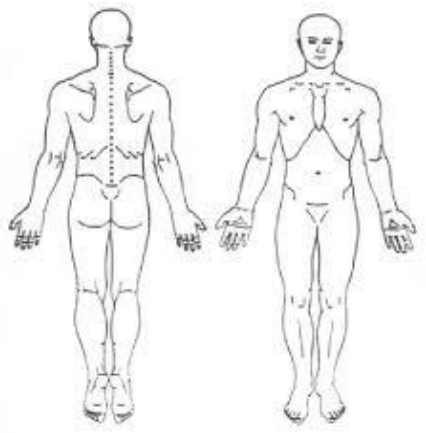
a. When did your symptoms start?_____

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 from 0-10 ——> 0——1——2——3——4——5——6——7——8——9——10

No Pain Very Painful

6. Who else have you seen for this health problem?_____

a. what diagnosis were you given?_____**what treatment provided?**_____

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/MRI/CT Scan?_____

For each condition 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	
❑	❑	Headaches	❑	❑	Asthma	❑	❑	Constipation
❑	❑	Neck Pain	❑	❑	Sinus Problems	❑	❑	Chest Pain
❑	❑	Middle Back Pain	❑	❑	Allergies_____	❑	❑	Stroke
❑	❑	Low Back Pain	❑	❑	Fibromyalgia	❑	❑	Heart Disease
❑	❑	Pain in Arms	❑	❑	Diabetes	❑	❑	Dizziness/Light Headed
❑	❑	Shoulder Pain	❑	❑	Anemia	❑	❑	Tuberculosis
❑	❑	Pain in Legs	❑	❑	High Blood Pressure	❑	❑	Hepatitis A,B, or C
❑	❑	Foot/Ankle Pain	❑	❑	Epilepsy	❑	❑	AIDS/HIV
❑	❑	Weakness	❑	❑	Nervousness/Depression	❑	❑	Cancer
❑	❑	Arthritis	❑	❑	Frequent Urination	❑	❑	Painful Urination
❑	❑	Numbness/Tingling	❑	❑	Premenstrual Syndrome	❑	❑	Recent Weight Loss/Gain
❑	❑	Joint Swelling/Stiffness	❑	❑	Kidney Stones	❑	❑	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. Female Patients: Are you currently pregnant? ❑ **Yes** ❑ **No** ❑ **Maybe**

If yes, how far along are you?_____**Last menstrual cycle began on**_____

Patient Signature _____**Date:**_____