Kingstowne Family Chiropractic

NEW PATIENT HEALTH HISTORY & QUESTIONAIRE

Chief Complaint: Please complete the areas below to indicate your current conditions or injuries.

Head/Neck_____

Frequency □Intermittent □Occasional □Frequent □Constant

Quality □sharp □stabbing □achy □sore □tight □stiff □tingly □burning □numb □Other_____

What makes it worse_____What makes it better_____

Please Rate Your Pain: No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Midback/Shoulders/Arms_____

Frequency □Intermittent □Occasional □Frequent □Constant

Quality □sharp □stabbing □achy □sore □tight □stiff □tingly □burning □numb □Other_____

What makes it worse_____What makes it better_____

Please Rate Your Pain: No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Low Back/Hips/Legs_____

Frequency □Intermittent □Occasional □Frequent □Constant

Quality □sharp □stabbing □achy □sore □tight □stiff □tingly □burning □numb □Other_____

What makes it worse_____What makes it better_____

Please Rate Your Pain: No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Symptoms have persisted for: □___Hours □___Days □___Weeks □___Months □___Years

Are your symptoms/condition: □Improving □Unchanged □Worsening

Have you seen another physician for these complaints? □Yes □No If Yes, Physician and Diagnosis_____

Have you had any X-rays, MRIs, or other tests performed? □Yes □No If Yes, what and when_____

Indicate your ability to perform the following: U=unable, L=limited, P=painful but able, N=normal

___Coughing/sneezing	___Rolling Over	___Sitting	___Dressing	___Brushing Teeth	___Standing
___Pushing/pulling	___Lying on back	___Driving	___Walking	___Lifting 15lbs	___Reading
___Reaching over head	___Sexual Activity	___Sleeping	___Balancing	___Tying shoes	___Concentrating

Medical History:

Do you or have you had any of the following:

□High Blood Pressure	□Unexplained Weight Loss/Gain	□Night Sweats	□Heart Disease	□Fainting
□Difficulty Breathing	□Difficulty Swallowing	□Memory Loss	□Loss of Consciousness	□Bowel/bladder Changes
□Abdominal Pain	□Numbness/Tingling	□Blurred Vision	□Loss of Sleep	□Stroke
□Rectal Bleeding	□Constipation/Diarrhea	□Cancer	□Chest Pain/Heart Attack	□Diabetes
□Current Fever	□Depression/Anxiety	□Arthritis	□Asthma/Allergies	□Hepatitis
□HIV/AIDS	□Anorexia/Bulemia	□Pacemaker	□Metal Implants	□Headaches

Please list any serious illnesses or conditions: _____

Please list any current medications: _____

Please list any current vitamins/supplements: _____

Men Only, Date of last prostate exam_____ Findings_____

Woman Only: Are you pregnant? □Yes □No Date of last menstrual Cycle_____

Work History:

Occupation_____How many hours a week do you work?_____Are you currently not working? □Yes □No

Please indicate the percentage of time you spend doing each of the following activities during your work day:

Sitting	□0	□10	□20	□30	□40	□50	□60	□70	□80	□90	□100
Standing	□0	□10	□20	□30	□40	□50	□60	□70	□80	□90	□100
Walking	□0	□10	□20	□30	□40	□50	□60	□70	□80	□90	□100
Lifting	□0	□10	□20	□30	□40	□50	□60	□70	□80	□90	□100
Other_____	□0	□10	□20	□30	□40	□50	□60	□70	□80	□90	□100

Social History:

Do you smoke? □Yes □No Packs per day_____

Do you drink alcohol? □Yes □No Drinks per week_____

Do you use recreational or illegal drugs? □Yes □No Drug and frequency use_____

Do you drink caffeine? □Yes □No Cups per day_____

Do you use sugar substitutes? □Yes □No

Do you exercise? □None □Light/Limited □Moderate □Heavy □Intense

Family History:

Please list any significant health history for the following members of your family:

Mother:_____

Father:_____

Siblings:_____

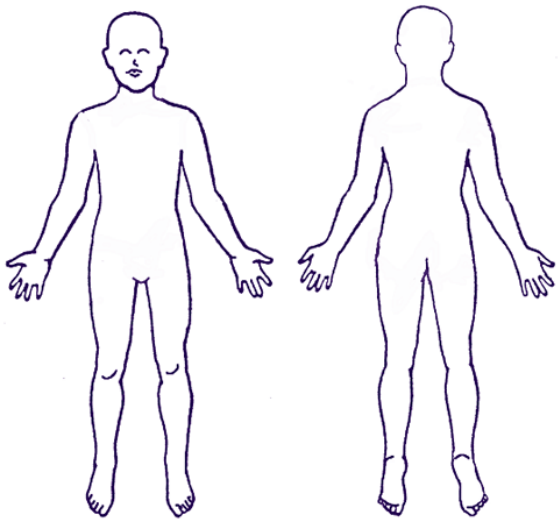
Maternal Grandparents:_____

Paternal Grandparents:_____

Pain Diagram:

Please indicate the symptoms you are having on the body diagrams according to the listed symbols:

*** Stiff/tight
xxx Burning
^^^ Aching
/// Stabbing/sharp
=== Numb
ooo Pins and Needles



Patient Signature_____Date_____