Belle Haven Family Chiropractic

NEW PATIENT HEALTH QUESTIONNAIRE

Please describe complaints below: (i.e. low back, shoulder, neck)

1. Involving head/neck: _____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
The pain is aggravated by: _____

The pain is relieved by: _____

2. Involving Mid Back/Shoulders/Arms & hands: _____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

3. Involving Lower Back/Hips/Legs & Feet's: _____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

Symptoms have persisted for: ❒ ____ Hours ❒ _____ Days ❒ ____ Weeks ❒ ____ Months ❒ _____ Years
Are your symptoms/condition: ❒ Improving ❒ unchanged ❒ getting worse
Have you seen another physician for these conditions? _____
If Yes, Physician name & tests performed: _____
Have you had x-rays or other tests performed for this condition? No Yes What / When
_____

Indicate your ability to perform the following activities: **U=Unable, P=Painful, D=Difficult, L=Limited, N=Normal**

_____ Coughing or sneezing	_____ Getting in or out of a car	_____ Bending forward to brush teeth
_____ Turning over in bed	_____ Walking short distances	_____ Prolonged standing
_____ Sitting at a table	_____ Lying on back	_____ Lifting up to 15 lbs
_____ Getting dressed	_____ Sleeping	_____ Pushing/Pulling
_____ Driving a car	_____ Reaching	_____ Sexual activity

MEDICAL HISTORY:

What MEDICATION are you presently taking and for what condition? _____
Have you ever been diagnosed with Cancer? ❒ No ❒ Yes Describe: _____

CHECK HERE IF YOU HAVE HAD OR ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

❒ Buzzing or ringing in ears	❒ Blurring vision	❒ Rectal bleeding
❒ Loss of bowel or bladder function	❒ Loss of sleep	❒ Dizziness
❒ Stomach difficulty/abdominal px	❒ History of Stroke	❒ Chest pain
❒ Confusion/loss of Memory	❒ Constipation	❒ Depression
❒ Frequent urination or painful	❒ Cancer	❒ Diarrhea
❒ Difficulty swallowing	❒ Allergies	❒ Asthma
❒ Unexplained weight loss/gain	❒ Current Fever	❒ Aids/HIV
❒ Heart Diseases	❒ Fainting	❒ Arthritis

❒ Numbness/Tingling ❒ Headaches: Area of head: _____

How often: ❒ ____ times/day ❒ ____ times/week ❒ ____ times/month

Do you have a pacemaker? ❒ Yes ❒ No Do you have any metal implants ❒ Yes ❒ No

Please list any serious illness or medical conditions you have had and associated treatment**:**

_____

_____

WORK HISTORY:

How many hours do you normally work in a week? _____ Are you currently not working? ❒ Yes ❒ No

In a typical workday, I: (circle the number of hours per day per activity)

Sit	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk	1	2	3	4	5	6	7	8	hours

Does your job require physical labor? If yes, please describe: _____

SOCIAL HISTORY:

Do you smoke? ❒ No ❒ Yes If yes, Packs per day _____

Do you drink caffeine? _____ ❒ No ❒ Yes: if yes, cups per day _____

Do you consume alcohol? ❒ No ❒ Yes; if yes, drinks per week _____

Exercise: ❒ Light ❒ Moderate ❒ Heavy/Intense ❒ None

FAMILY HISTORY: Please list any family history of heart disease, cancer, diabetes or other serious illness:

Father: _____ Mother: _____ Siblings: _____

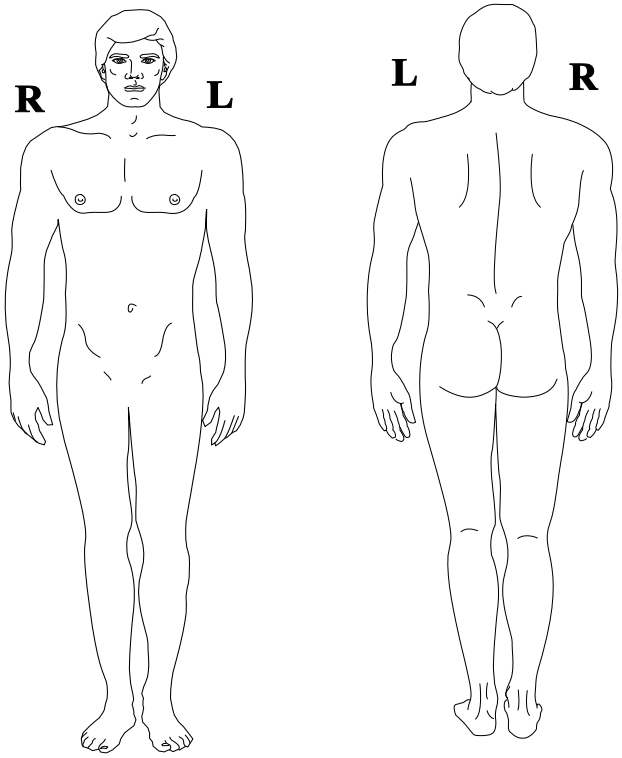
Woman Only: Are you pregnant? ❒ Yes ❒ No Date of last menstrual cycle: _____

Men Only: Last Prostate exam: _____ results: _____

PAIN DIAGRAM

Use these symbols to describe the type of pain or sensations you are feeling:

***	**Stiffness**
>>>	**Aching pain**
///	**Stabbing or Sharp**
XXX	**Burning pain**
===	**Numbness**
ooo	**Pins and Needles**



Patient's Name: _____ Patient's Signature: _____ Date: ___/___ /____

(Or guardian if child)