PUFFIN CHIROPRACTIC
FAITH FAMILY WELLNESS

Puffin Chiropractic Health Questionnaire

Patient Information

Date: _____ **How did you hear about us?_____**

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Phone number:_____ Home Address:_____

List all prescription, non prescription medications and other supplements you take as well as the associated condition(s):

_____
_____
_____
_____
_____
_____

List any surgeries or hospitalizations you have ever had complete with the month and year for each:

_____
_____
_____
_____
_____

List anything you are allergic to:

_____
_____
_____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual) (Has anyone in your family passed away before age 50?) (Any known cancer, heart, brain, bone disease?):

_____
_____
_____
_____
_____

What is your occupation?_____

Do you exercise? □ Yes □ No Hours per week What activity(s)?

_____

_____

_____

Are you dieting**?** □ Yes □ No Since: Do you smoke? □ Yes □ No _____packs per day.

How many years have you been smoking? Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heel lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks?

_____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

_____

_____

_____

_____

Are you here because of an accident?_____ If yes, What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

_____

How often do you experience symptoms? **(Circle one)** Constantly Frequently Occasionally Intermittently

Describe your symptoms? **(circle all that apply)** Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? **(Circle one)** Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?

_____

_____

_____

_____

Have you experienced these same/similar symptoms in the past?

_____
_____
_____
_____

Are you having problems with bowel or bladder? _____ Have you had fever/infection in the past 2 weeks? _____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? Yes No
Did they/have you ever taken spinal X-rays? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

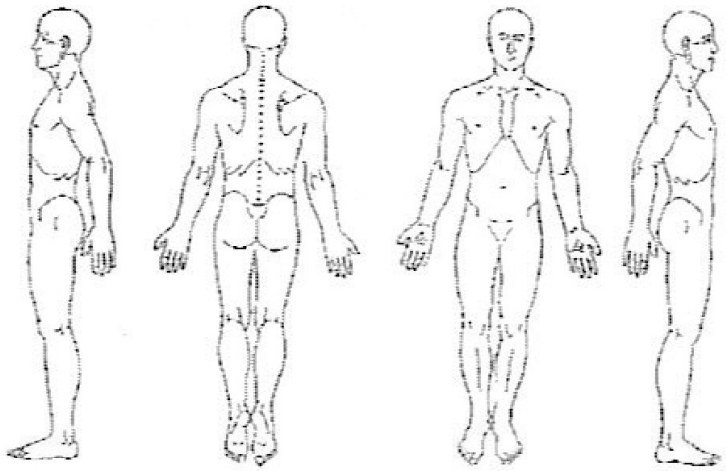
_____
_____
_____
_____
_____

Description of Condition

Mark any area(s) of discomfort with the following key:

On a 0 to 10 scale (0 is no pain, 10 is Emergency Room); What is your worst?_____, Average?_____, Best?_____

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gallbladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systemic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

***Emergency Contact:** Name: _____ #:_____ Relationship:_____

Additional comments you would like the doctor to know: _____

_____

_____

_____

_____

_____

Patient's signature: _____ **Doctor's signature:** _____

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