Demyen Family Chiropractic
770.720.2222
www.demyenchiro.com

Patient # _____

"A Revolutionary Approach to Healthcare!"

ADULT HEALTH HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

CURRENT COMPLAINT #1: ☐ Neck ☐ Low-Back ☐ Mid-Back ☐ Shoulder ☐ Leg ☐ Other _____

Where? _____ Date of Onset: _____ Cause: _____

Description: ☐ Burning ☐ Stabbing ☐ Aching ☐ Boring ☐ Tingling ☐ Stiff ☐ Throbbing

How Often? ☐ Constant ☐ Intermittent Radiating? ☐ R ☐ L ☐ Both / ☐ Leg ☐ Arm ☐ Waist ☐ Other

Anything Relieve It? _____ Aggravate It? _____

Has Condition Got: ☐ Better ☐ Worse ☐ Staying Same

Have you ever experienced this condition before? ☐ Yes ☐ No If Yes, When? _____

Is condition effecting your: ☐ Home Life ☐ Occupation ☐ Recreational Activities ☐ Rest & Sleep

Anyone else seen for this condition? ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist

CURRENT COMPLAINT #2: ☐ Neck ☐ Low-Back ☐ Mid-Back ☐ Shoulder ☐ Leg ☐ Other _____

Where? _____ Date of Onset: _____ Cause: _____

Description: ☐ Burning ☐ Stabbing ☐ Aching ☐ Boring ☐ Tingling ☐ Stiff ☐ Throbbing

How Often? ☐ Constant ☐ Intermittent Radiating? ☐ R ☐ L ☐ Both / ☐ Leg ☐ Arm ☐ Waist ☐ Other

Anything Relieve It? _____ Aggravate It? _____

Has Condition Got: ☐ Better ☐ Worse ☐ Staying Same

Have you ever experienced this condition before? ☐ Yes ☐ No If Yes, When? _____

Is condition effecting your: ☐ Home Life ☐ Occupation ☐ Recreational Activities ☐ Rest & Sleep

Anyone else seen for this condition? ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist

PAST HISTORY:

Automobile accidents? ☐ Past Year: 1 2 3+ ☐ Past 5 Years: 1 2 3+ ☐ Over 5 Years: 1 2 3+ ☐ Never

EMS: ☐ Yes ☐ No Hospitalized? ☐ Yes ☐ No If Yes, how long? _____

Previous Surgeries: _____

Serious Injuries: _____

Traumas (slips/falls/breaks)? _____

Illnesses? _____ Previous Chiropractor? _____

NOTABLE HEALTH CONCERNS:

Allergies? ☐ Yes ☐ No If Yes, please list: _____

Current Medications: _____

_____

Other: _____

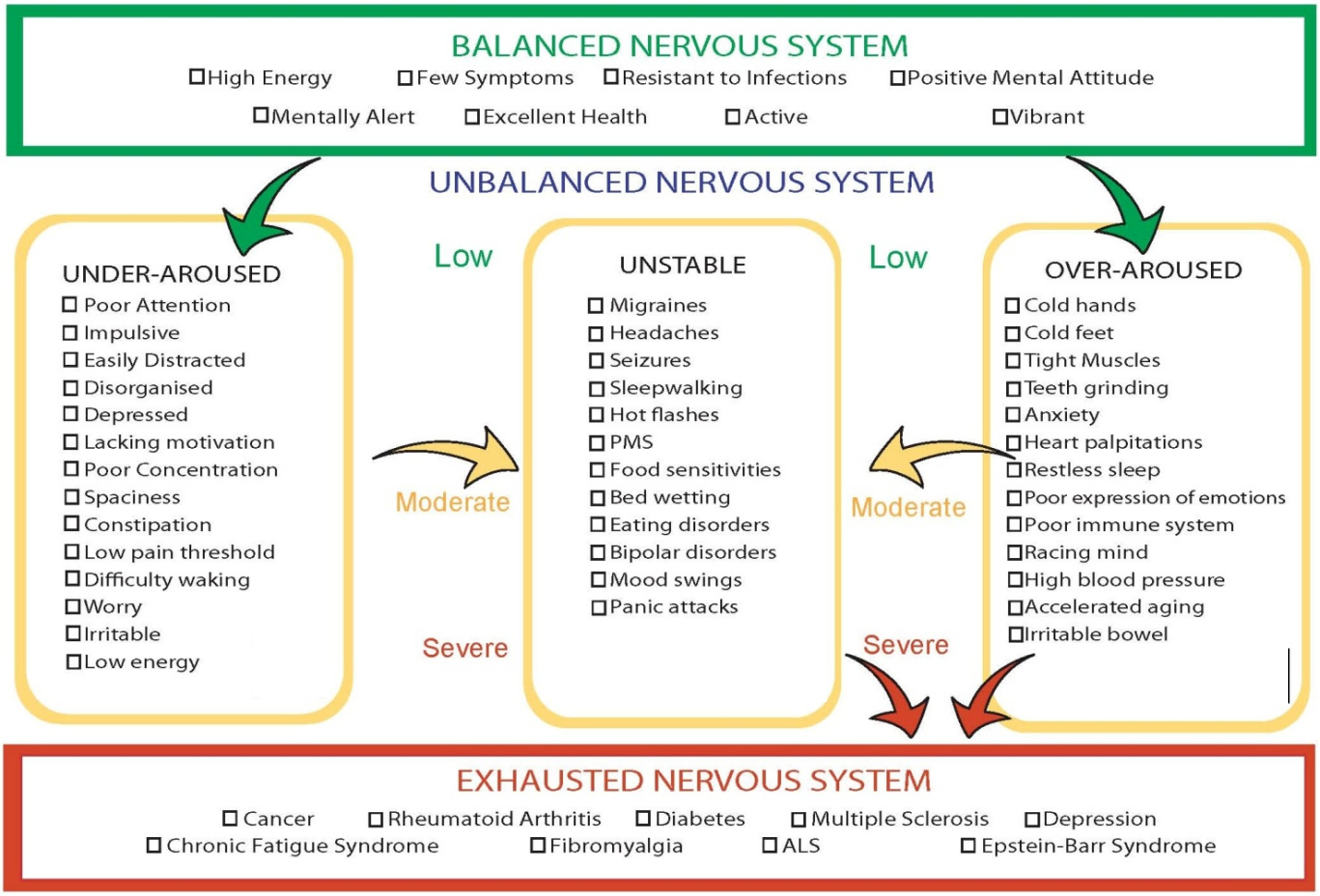
_____

Please rate your current level of Stress (1 = No Stress; 5 = Moderate Stress; 10 = Overwhelming Stress):

1 2 3 4 5 6 7 8 9 10

NAME: _____ DATE: _____ Patient # _____

Please check all symptoms that you have ever had, even if they do not seem related to your current problem, where you believe you fit on the chart. Your doctor will then be able to recommend what type of care you need to achieve balance... where are your loved ones?



CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia	☐ Tuberculosis	☐ Measles	☐ Chicken pox	☐ Arthritis
☐ Rheumatic fever	☐ Whooping cough	☐ Mumps	☐ Thyroid	☐ Mental disorders
☐ Polio	☐ Anemia	☐ Small pox	☐ Influenza	☐ HIV

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

NERVOUS SYSTEM
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold/tingling extremities

MUSCULOSKELETAL
- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/stiffness
- ☐ Walking problems
- ☐ Difficulty chewing/clicking jaw
- ☐ General stiffness

GASTROINTESTINAL
- ☐ Poor/excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Liver problems
- ☐ Gall bladder problems
- ☐ Weight trouble
- ☐ Gas/bloating after meals
- ☐ Heartburn
- ☐ Black/bloody stool colitis

GENITOURINARY
- ☐ Painful/excessive urination
- ☐ Discolored urine

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems/congestion
- ☐ Varicose veins
- ☐ Ankle swelling
- ☐ Stroke

EYE/EAR/NOSE/THROAT
- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Ear aches
- ☐ Hearing difficulty
- ☐ Stuffed nose

MALE/FEMALE
- ☐ Menstrual cramps
- ☐ Vaginal pain/infection
- ☐ Breast pain/lumps
- ☐ Prostate/sexual dysfunction

FEMALES ONLY
- ☐ Normal menstrual cycle
- ☐ Irregular menstrual cycle
- ☐ Menopause/hysterectomy
- ☐ Pregnant

Would you like additional information about nutritional intervention for weight loss? ☐ Yes ☐ No