



HEALTH QUESTIONNAIRE

Personal Information

Full name _____ Name you wish to be called _____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail: _____

Date of birth ____/____/____ Age: ____ Gender: M/F Insurance Company: _____

Occupation: _____ Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

Primary Concern

What brings you to our clinic?

Date of original condition: _____ Date of most recent occurrence: _____

Was there an event that created the condition?

Have you had this or similar conditions in the past? _____

What makes it better? _____ Worse? _____

Is the condition getting worse? _____ Constant? _____

Worse at a certain time of day? _____

Is this condition interfering with: Work? _____ Sleep? _____ Activity? _____ Other? _____

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

Health History

List other current health issues & problems:

List other practitioners seen, treatments, self-care activities, and results:

List illness you have had not previously mentioned, if any:

List all surgeries you have had, with dates and results:

Have you ever been in an accident or seriously injured? (if so, please describe)

Do you have any dental or TMJ problems? Y N (if so, please describe)

Medication	Dosage	For Which Condition?	How long have you been taking this?

Have you had your wisdom teeth or other teeth removed? Y N *Have you ever had a root canal? Y N (if yes note which teeth) _____

List all vitamins, herbs and other supplements you are now taking, the dose, and reason for taking:

List all medications and other substances (i.e.: foods) to which you are allergic:

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother _____

Children _____ Grandparents _____

Brothers _____ Sisters _____

General

*Describe your use of: Cigarettes/Tobacco _____ Alcohol _____
 Other drugs _____

*Describe your present exercise habits including frequency per week, duration, and heart rate:

* How many hours per night do you sleep? _____ * Do you fall right asleep? Y N

Physical Activity

*Type of sport/activity/exercise routine you participate in:

* Do you wear orthotics/arch supports/or any other devices during the day or when you exercise?

*Have you progressed, regressed, or plateaued in the past year? (circle)

*How many injuries (minor included) or illnesses do you suffer from per year? _____

*If applicable: When & what is your next competition you hope to participate in, or which one do you wish to "peak" for?

Pain Questionnaire

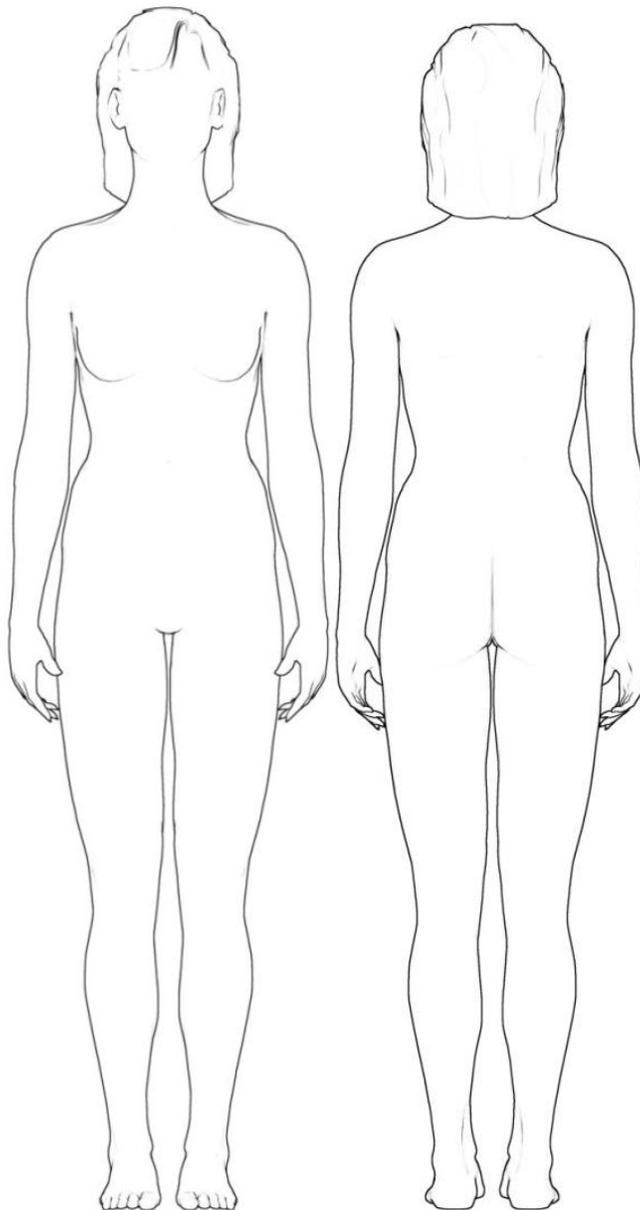
(Skip to the next section if you are not currently experiencing pain.)

Please place a single vertical line through the scale below at the point that best describes your pain. (0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

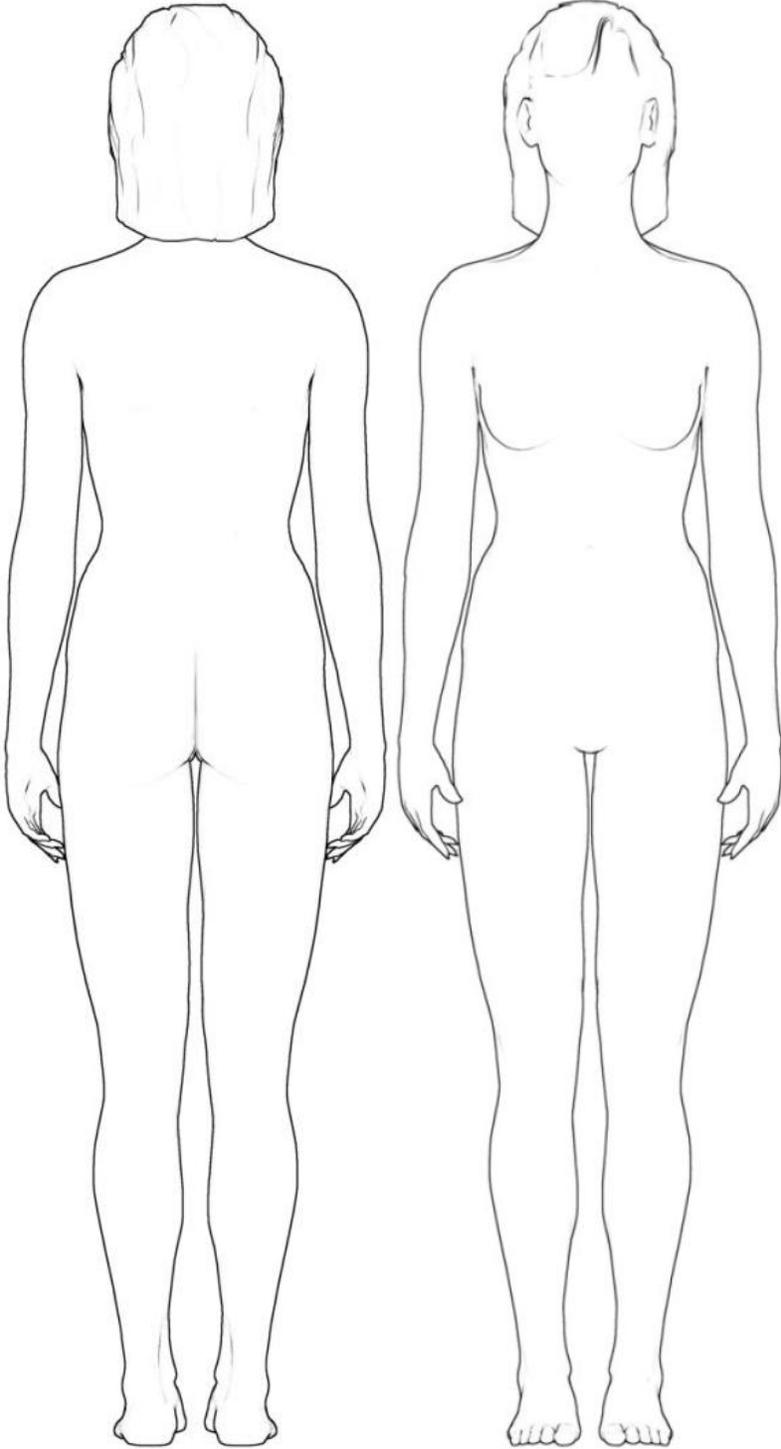
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache B = Burning N = Numbness O = Other P = Pins & Needles S = Stabbing T = Throbbing



History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



Diet History

How much do you drink each day (**8oz**): Water:_____ Juice: _____ Soda Diet: _____

Soda Regular: _____ Coffee: Regular: _____ Decaf: _____ Tea: Regular:_____ Tea Sweet :_____

Energy Drinks/Other:_____

List oils or fats that you use in cooking:

Do you frequently skip meals? Y N

Are you on any special diet or nutrition program? Y N Describe:

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.

Circle the foods you crave: Meats, Fats, Sweets, Salty, Foods, Vegetables, Fruits, Breads, Spicy Foods, Sour Foods, Cereals, Dairy, Other: _____

*Do you eat from fast food restaurants? Y N -- If yes, how often? _____

What do you usually eat for **breakfast**?_____

What do you usually eat for **lunch**?_____

What do you usually eat for **dinner**?_____

What do you usually eat for **snacks** (in between meals and/or before bed)?

What foods do you eat a lot of (at least once a day, every day)?

How many bowel movements do you have per day? _____

Name(print):_____

Sign:_____ Date:_____