**Health Questionnaire**
(Please print and fill in form completely)

Current Health Concern(s): ________________________________________
____________________________________________________________

Is this Concern Related to a: sports injury surgical procedure auto accident
work accident gradual problem other: ________________

If this is auto or work related, please provider insurance information and adjustor or claims processor: ________________________________________________
____________________________________________________________

When Did Current Signs and Symptoms Begin: ___________________________

Describe Symptoms: ______________________________________________
____________________________________________________________

Please list all of your medications, vitamins and supplements including dosage and frequency:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

**Please Check Any Medical, Rehabilitative or Other Providers or Services You Have Seen or Had for this Condition:**

___Orthopedist ___Primary Care Physician ___Neurologist ___Podiatrist
___Chiropractor ___Acupuncturist ___Physical Therapist ___Physiatrist
___Massage Therapist ___ER Visit ___X-rays ___MRI ___CT Scan
___EMG ___Injection ___Cast or Brace ___Other____________________

**Please Check All Conditions That Apply to You:**

___ Neck Pain
___ Joint Pain
___ Back Pain
___ Leg Pain
___ Arm Pain
___ Fractures
___ Joint Dislocation
___ Joint Subluxation
___ Strains/Sprain
___ Disc Problems
___ Scoliosis
___ Muscle Tension
___ Weakness
___ Limited Motion
___ Jerking/Twitching

___ Metal Implants
___ Prosthesis
___ Arthritis
___ Headaches
___ Visual Changes
___ Sinus Trouble
___ Hearing Concerns
___ Chronic Earaches
___ Tinnitus
___ Asthma
___ COPD/Lung Disease
___ Neurological Disorders
___ Parkinson's

___ Paralysis
___ Dizziness
___ Vertigo
___ Balance Concerns
___ Multiple Sclerosis
___ Stroke/TIA
___ Seizures
___ Numbness/Tingling
___ Cancer
___ Poor Appetite
___ Thyroid
___ Digestive Disorders
___ Bladder Concerns
___ Bowel Concerns
___ Nausea

___ Liver Disease
___ Hepatitis
___ Kidney Disease
___ Diabetes
___ Heart Disease
___ PVD
___ Hypertension
___ Anemia/Blood Disorders
___ Pacemaker
___ Excessive Stress
___ Fibromyalgia
___ Fatigue

**Allergies** (Please list any and all allergies including allergies to medications):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Surgeries & Hospitalizations** (Please list any and all surgical procedures and hospitalizations with dates if known):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Family Medical History** (Please list any significant family history of illness or disease):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

How Many Hours of Sleep to you average per night? ______________________________

Do you Smoke? Y N Packs per Day: _____________________

Do you Drink Alcohol? Y N Drinks per Week: ___________________

Do you Exercise Regularly? Y N Days per Week: ____________________
Type: _________________________________________________________

Are you Pregnant or think you might be? Y N

Do you have a history of complicated pregnancies and deliveries? Y N