

CHIROPRACTIC HEALTH QUESTIONNAIRE

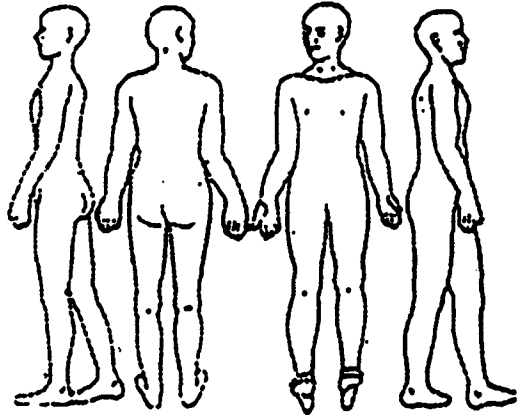
Langel Chiropractic Clinic, P.C.
5907 Ashworth Road
West Des Moines, IA 50266
515-267-1600

Patient Name _____ Birthdate _____ Date _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone () _____ Cell # () _____ Email _____
 Social Security Number _____ Patient Employed by _____
 Business Address _____ City _____ State _____ Zip _____
 Position _____ Business Phone () _____ Job Type (Circle One) FT PT Temp
 How many hours per week do you work? _____ How long have you had this position? _____ yrs. _____ mo. Married? Y N
 Spouses Name _____ Date of Birth _____ Social Security No. _____
 Spouse Employed By _____ Business Phone () _____
 Business Address _____ City _____ State _____ Zip _____
 Person Responsible for this account _____ How did you hear about us? _____
 Primary Medical Insurance (present card(s) to the chiropractic asst.) _____
 Reason for visit _____

Have you been treated before for this problem? No Yes
 If yes, by Physician Physical Therapist Osteopath. Other _____
 What did they say/recommend? _____
 When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No Unknown
 Are your symptoms constant, or do they come and go? _____ Does it interfere with your Work Sleep Daily routine Recreation
 Activities or movements that are painful to perform Sitting Walking Bending Lying Down
 Other _____

Describe your activities at work (example: sitting, lifting, etc.) _____
 Have you ever had chiropractic care for other problems? Yes No When? _____
 Do you take Muscle relaxers Pain killers Insulin Birth Control Pills Over-the-counter medicines
 Other prescription drugs _____ (Please list all medications you take in the space on the next page)
 Date of last: Physical Exam _____ Spinal x-ray _____ Blood Test _____
 Spinal Exam _____ Chest x-ray _____ Urine Test _____
 Dental X-ray _____ MRI, CT-scan, bone scan _____

Sleep _____ hrs./night Do you sleep on your Back Side Stomach Non-job exercise _____ hrs./wk.
 Age of mattress _____ or waterbed _____ Is your bed comfortable? Yes No
 What kind of pillow do you use? Thick Medium Thin None Support
 Do you wear? Heel lifts Shoe lifts Arch supports Orthotics, describe _____



Please indicate on the body what type of sensation(s) you are experiencing.

- P = Pain
- N = Numb
- S = Spasm
- T = Tender
- H = Hypoesthesia

Please rate each area of complaint on the pain scale.

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

Doctor's Signature _____

Patient Accepted Y N

MEDICATIONS List medications you are currently taking	VITAMINS/HERBS/MINERALS
Allergies _____	

GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL <input type="checkbox"/> Bruise easily <input type="checkbox"/> Chills <input type="checkbox"/> Dental Problems <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Tiredness <input type="checkbox"/> Weight gain	GASTROINTESTINAL <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	EYE, EAR, NOSE, THROAT <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - flashes <input type="checkbox"/> Vision - halos	MEN only <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other WOMEN Only <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other	GENITO URINARY <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful Urination CARDIOVASCULAR <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins SKIN <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal
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Date of last menstrual period _____ Date of last pap smear _____

Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____

NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past year.

NECK <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck weakness <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck <input type="checkbox"/> Grinding/popping sounds in neck SHOULDERS <input type="checkbox"/> Pain in shoulder joint <input type="checkbox"/> Pain across shoulders <input type="checkbox"/> Can't raise arm <input type="checkbox"/> Above shoulder level <input type="checkbox"/> Over head <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Pinched nerve in shoulder MID-BACK <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Mid-back stiffness <input type="checkbox"/> Pain between shoulder blades	<input type="checkbox"/> Pain from front to back <input type="checkbox"/> Muscle spasms in mid-back ARMS & HANDS <input type="checkbox"/> Pain in upper arm <input type="checkbox"/> Pain in elbow <input type="checkbox"/> Pain in forearm <input type="checkbox"/> Pain in hand <input type="checkbox"/> Pain in fingers <input type="checkbox"/> Pins & needles in arm <input type="checkbox"/> Pins & needles in fingers <input type="checkbox"/> Numbness in arm <input type="checkbox"/> Numbness in fingers <input type="checkbox"/> Weakness of arm <input type="checkbox"/> Weakness of hand <input type="checkbox"/> Hands cold LOW BACK <input type="checkbox"/> Low back pain <input type="checkbox"/> Low back stiffness <input type="checkbox"/> Low back weakness <input type="checkbox"/> Pinched nerve in low back	<input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms in low back HIPS, LEGS & FEET <input type="checkbox"/> Pain in buttocks <input type="checkbox"/> Pain hip joint <input type="checkbox"/> Pain down leg <input type="checkbox"/> Pain in knee <input type="checkbox"/> Pain in ankle <input type="checkbox"/> Pain in foot <input type="checkbox"/> Weakness of leg <input type="checkbox"/> Weakness of knee <input type="checkbox"/> Leg cramps OTHER SYMPTOMS <hr/> <hr/> <hr/> <hr/>
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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature	Date
Reviewed by _____ Doctor	Date