Robert Schellenberg D.C., P.A.

# Health Questionnaire

Patient Name:_____ Date:_____

## Medical History

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

_____

_____

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

What makes it better?_____ What makes it worse?_____

Worse time of day: (Circle one) Morning As day progresses Night Site of pain: _____

Describe your symptoms: (circle all that apply) Sharp Dull Achy Numbing Burning Tingling Shooting

Does it radiate? □Yes □ No If so, where? _____

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

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 symptoms in the past?_____

Are you here because of an accident? □ Yes □ No Date of accident: _____

The accident was: (Circle one) Auto related Work related Other:_____

If accident is auto related name of attorney is:_____

Describe your accident_____

## History of Treatment

Primary care physician: _____ Address and Phone: _____

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

Have you seen a chiropractor before? □ Yes □ No Date last treated by Chiropractor before today:_____

Name of Chiropractor:_____ Address & phone: _____

Have you seen another doctor for these symptoms? □Yes □ No If yes, indicate name and type of medical provider: _____

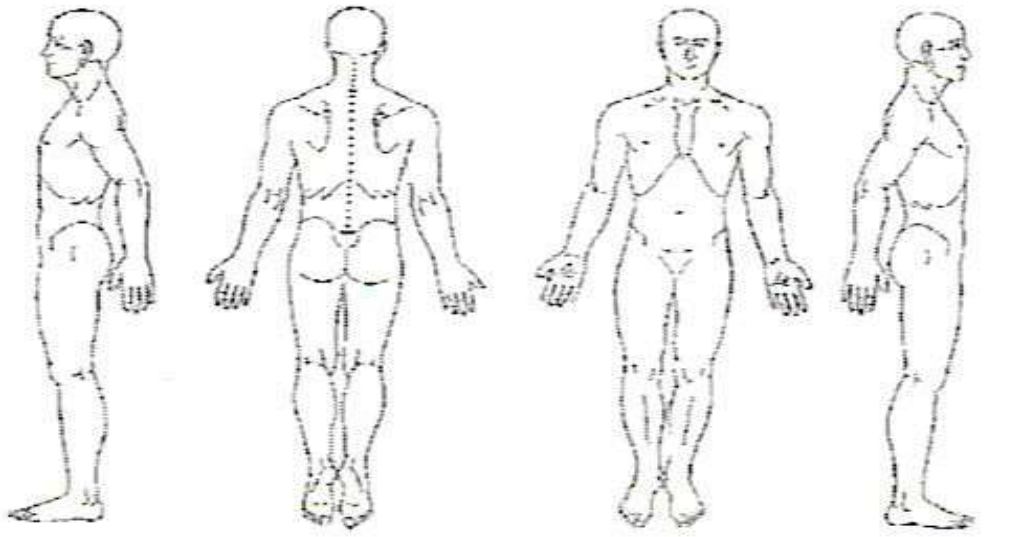
_____

Patient Name:_____ Date:_____

## Description of Condition

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

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




On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

## Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____ Age:_____

Height: _____Weight: _____ Right handed □ Left handed □

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

_____

_____

_____

List any surgeries or hospitalizations you have 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 affected):

_____

_____

_____

Do you exercise? □ Yes □ No How many 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: _____ Number of children: _____

**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/Gall Bladder 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 | ○ | ○ | Systematic 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 |

Check here if you have NOT experienced any of the conditions above ○.

Additional comments you would like the doctor to know: _____

_____

_____

_____

**Patient's signature:** _____ **Date:** _____

**If patient is under age 18 parent or legal guardian name:**_____

**Parent or legal guardian signature**: _____ **Date:**_____

**Doctor's signature:** _____