Morris CHIROPRACTIC

Patient Name:_____

New Patient Health Questionnaire **Date:**_____

Do you PRESENTLY have or have you had in the PAST persistent or recurring symptoms such as:
(neck pain, shoulder/arm pain, upper back, lower back, hip/leg pain)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____
Treatments received?_____
_____

Do you PRESENTLY have or have you had in the PAST any muscle, tendon, ligament, bone, or joint symptoms/diagnoses such as:
(muscle weakness, oseteoporosis, scoliosis, rheumatoid arthritis, ankylosing spondyolitis)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Please list any physical injuries such as falls or blows, automobile accidents, work injuries, whiplash, concussions, or head injuries, as well as any sprains, strains, dislocations, or broken bones, and when they occurred:
1._____Date:_____
2._____Date:_____
3._____Date:_____

Have you had spinal x-rays, MRI, CT scan? □ No □ Yes, Date(s) taken:_____
_____

Review of Systems:
Do you PRESENTLY have or have you had in the PAST any heart/circulation symptoms/diagnoses such as:
(frequent bruising, irregular heartbeat, swelling, of extremities, heart disease, heart attack)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any breathing/lung symptoms/diagnoses such as:
(persistent cough, shortness of breath, coughing up blood, tuberculosis)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any allergies, childhood diseases, etc. such as:
(corticosteroid use, measles, mumps, rubella, polio, allergies to foods, environment – hay fever, medications – Penicillin)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any ears/nose/throat symptoms/diagnoses such as:
(hearing loss, decrease/loss of smell, decrease/loss of taste, difficulty swallowing, neck lump/mass)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any nervous system symptoms/diagnoses such as:
(seizures, loss of consciousness, speech problems, migraines, stroke, difficulty walking/coordination)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST eye symptoms/diagnoses such as:
(loss of vision, blurred vision, eye discharge, wear corrective lenses)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any genital or urinary symptoms/diagnoses such as:
(loss of bladder control, burning urination, pins/needles/numbness around groin/buttocks, kidney infection, STD's)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any gland/hormone symptoms/diagnoses such as:
(excessive thirst, thyroid trouble, diabetes)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any digestive/intestinal symptoms/diagnoses such as:
(loss of control of bowel, bloody/black stools, colon/bowel disorder, liver trouble, hepatits)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any blood/lymph symptoms/diagnosis such as:
(easy bruising, swollen glands/nodes, anemia, leukemia, HIV/Aids)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any skin, hair, nail symptoms/diagnoses such as:
(sore/wound that will not heal, eczema, changes in skin/nails/wart/mole)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any mental health symptoms/diagnoses such as:
(depression, anxiety disorder)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Do you PRESENTLY have or have you had in the PAST any constitutional symptoms/diagnoses such as:
(unusual weight loss/gain, night sweats, pain that wakes you up at night, cancer)
□ No
□ Presently I am having_____
_____

□ I've had in the past_____
_____

Any other conditions not covered above?:_____

_____

_____

Females:

□Yes □ No Menstrual problems
□Yes □ No Irregular periods
□Yes □ No Endometriosis
□Yes □ No PMS
□Yes □ No Menopause
□Yes □ No Hot flashes
□Yes □ No Breast lumps/pain
□Yes □ No Breast enhancement or reduction
□Yes □ No Birth control?_____
Number of pregnancies_____
Number of births_____
Date of last gynecological exam:
_____/_____

Males:

□Yes □ No Impotence
□Yes □ No Testicular masses/lumps/pain
□Yes □ No Prostate problems
□Yes □ No Date of last prostate exam:
_____/_____

Gender and ages of children:
_____
_____
_____
_____

Medications: List any medications, and/or supplements you are currently taking (include aspirin, Advil, vitamins, herbs, corticosteroids, etc.):
Medication:_____Condition used for:_____
Medication:_____Condition used for:_____
Medication:_____Condition used for:_____
Medication:_____Condition used for:_____
Medication:_____Condition used for:_____

Hospitalizations/Surgical Procedures: List any surgeries you have had (include appendix, tonsils, hysterectomy, orthopedic, implants, pacemaker, etc.):_____Date:_____
_____Date:_____
_____Date:_____
_____Date:_____

Health Care
Have you ever been to a chiropractor? □ Yes □ No When?_____
For what?_____
Do you have a family physician? □ Yes □ No Name:_____
Date of last physical exam:_____
Other health professionals you have seen (physical therapist, acupuncturist…):_____
_____

Family History
Are there any diseases or conditions that are common among your family members? □ Yes □ No
□ Cancer? Who:_____ □ Diabetes? Who:_____
□ High blood pressure? Who:_____ □ Stroke? Who:_____
□ Cardiovascular problems? Who:_____ □ Kidney disease? Who:_____

Work Habits
Please describe your work; check all that apply:
Type: □ Professional □ Physical Labor □ Driver □ Clerical □ Factory □ Homemaker
How long have you been with your present employer?_____
Job satisfaction: □ Unsatisfied □ Satisfied □ Very satisfied
Physical Demands: □ Heavy □ Moderate □ Mild □ Sedentary □ Lifting _____lbs.
□ Bending □ Twisting □ Stooping □ Carrying
Number of Hours: ____ Sitting ____ Computer usage ____ Using phone
____ Standing _____ Driving

Do you have permanent disability? □ No □ Yes, of_____
Date rating was received:____/____/_____
Rating percentage?_____%

Social Habits
□ Married □ Single □ Divorced □ Widowed □ Student
Stress Level*:* □ High □ Medium □ Low
Do you exercise on a regular basis? □ Yes □ No How?_____
How do you spend your spare time (hobbies, etc.)?_____
Do you actively □ garden, □ do housework, □ do yard work?
Your diet is: □ Balanced □ Fair □ Poor □ Excessive □ Restricted
Have you or do you use: □ Tobacco? _____packs/day □ Recreational drugs? □ Alcohol? _____ drinks/day/week
□ Anabolic steroids? □ Caffeine? (circle one or more) Soda Coffee Tea _____/day
Have you received treatment for drugs, alcohol or smoking? □ Yes □ No
Sleep Habits: In what position do you usually sleep?_____ How well do you sleep?_____Average hours per night:_____

_____ Date:_____
Patient Signature

Recorded by:_____