



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, osteoporosis, scoliosis, rheumatoid arthritis, ankylosing spondylitis)

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, hepatitis)

- 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: _____

Patient Signature Date: _____

Recorded by: _____