

CONFIDENTIAL PATIENT QUESTIONNAIRE

Dear Patient:

Today's Date: ____/____/____

In order for us to better help you, we need this important confidential questionnaire answered completely by you for your health care. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for your health! Thank you.

Name _____ Prefer To Be Called _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Work Phone _____
Sex M F Marital Status Single Married Widowed Divorced Age _____ Date of Birth _____
Occupation _____ Employer _____ Years Employed _____
Employer's Address _____ City _____ State _____ Phone _____
Spouse's Name _____ Occupation _____ Number of Children _____

Have you ever had Chiropractic Naturopathic care before? Yes No For what problem? _____
What type of care / treatment are you seeking from this clinic? Chiropractic Naturopathic Physical Therapy Whatever Helps
You were referred to this clinic by Newspaper Ads Web Friend Clinic Sign Other _____

What is your major complaint for which you came to our clinic? _____

Other complaints _____

Please describe in detail how your present illness developed / started from first sign and / or symptom to the present (includes time, place, reasons, courses, mode, results, etc.)

Are your symptoms the result of an auto accident, work- related injury or other personal injury(slip and fall, etc.)? If you answered yes, please fill out accident specific form, available at the front desk. Yes No

Did symptoms/pain begin gradually suddenly?

When was the very last episode of symptoms/discomforts experienced? _____

How long have you had these episodes of symptoms? _____

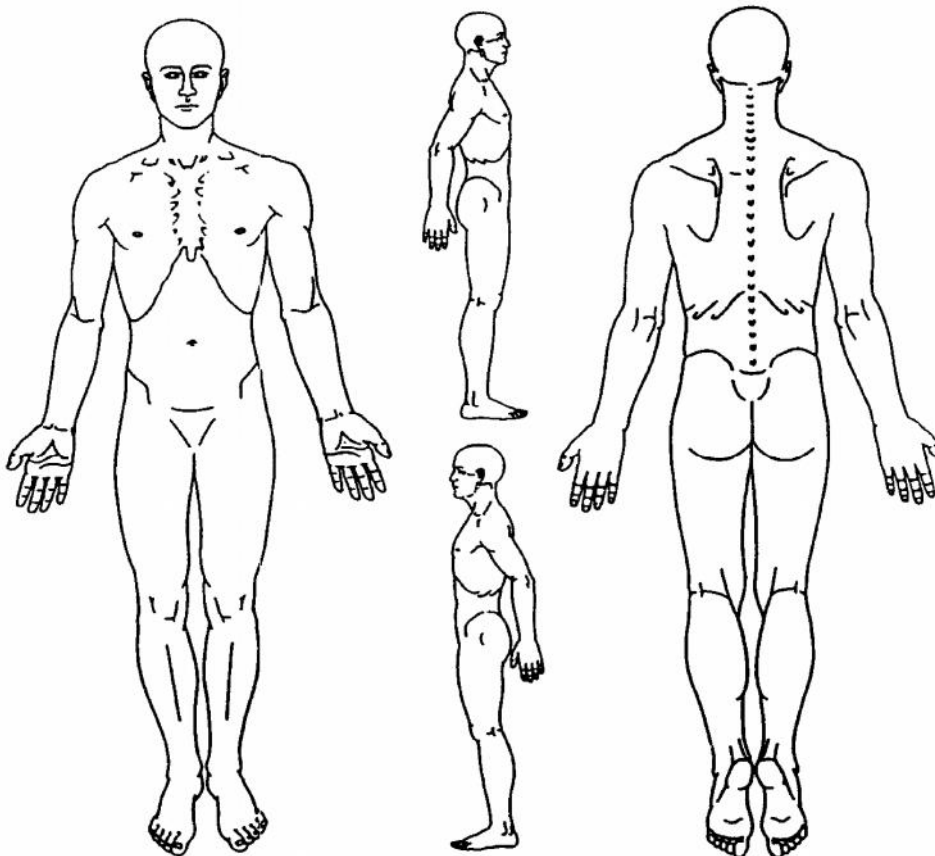
Please describe in detail how your health problem (s) disturbed / bothered you (including how each of the problems you described).

Are your symptom (s) / pain localized traveling? Please describe where your symptom (s) / pain go to _____

Describe the quality / character of your symptom(s). Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc.

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache	>>>>>	Numbness	=====	Pins and Needles	↓↓↓↓↓↓	Burning	×××××
Stabbing	▽▽▽▽▽	Throbbing	~~~~~	Tingling	+++++	Sharp	↔↔↔↔↔
Dull	0 0 0 0 0	Soreness	○○○○○	Shooting	⊕ ⊕ ⊕ ⊕	Other	



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort, please circle.

What is your pain/discomfort like today?

-0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

What is your least pain/discomfort?

-0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

What is your worst pain/discomfort?

-0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

How much time during an average day are you in pain/discomfort?

- Less than 1 hour per day
- Between 1 and 4 hours per day
- Between 4 and 8 hours per day
- Almost anytime that you are not lying down
- Almost 24 hours per day
- Other _____

Since your symptoms began, have they improved worsened stayed the same?

What made your current symptoms worse? _____

What made your current symptoms better? _____

Review of Systems

Circle if the symptom has occurred in the last year.
 Place a check mark if the symptom has occurred in the past.

General ___ No Problems	Weight gain Weight loss Significant weight loss or gain History of dieting	Chronic fatigue Fatigue in the afternoon Weakness Excessive thirst Intolerance to heat	Spontaneous sweating Night sweats Fever/Chills Sick more than 1 time/year	Intolerance to cold Cold hands/feet Other:
Skin ___ No Problems	Dry skin Itchy skin Rashes Hives Moist skin Bruising easily	Acne Eczema Psoriasis Shingles Ringworm Changes to nails	Athlete's foot Moles Bumpy skin on back of arms Spider/varicose veins Changes to skin color	Changes to moles Nail fungus Nail ridges Other:
Head ___ No Problems	Headaches Migraines Hair loss	Dizziness Vertigo Trauma	Other:	
Eyes ___ No Problems	Dry eyes Watery eyes Itchy eyes Eye pain Red eyes Discharge from eyes	Floater/Hallo/flashes Blurred vision Impaired vision Double vision Eyes sensitive to light Poor night vision	Sties Cataracts Vision loss Other:	Vision correction: Vision: Near__ Far__ Contacts Glasses Laser
Ears ___ No Problems	Ear pain Itchy ears Waxy ears	Discharge from ear Ringing in ears Hearing loss	Ear infections Ear infections as a child	Other:
Nose & Sinuses ___ No Problems	Itchy nose Discharge from nose Congested nose/sinuses	Postnasal drip Nosebleeds Loss of smell Breathe through mouth	Snore Other:	
Mouth & Throat	Dry mouth Itchy mouth/throat Sores on mouth/lips Hay fever/allergies Bad breath	Frequent sore throat Coughing up blood Persistent cough Difficulty swallowing Loss of Taste Hoarseness	Dentures Inflamed/bleeding gums Cavities Braces Teeth sensitivity	Jaw clicks TMJ Other dental concerns Treatment for strep. infections as a child Other:
Neck ___ No Problems	Neck pain or stiffness Trauma	Swollen glands	Other:	
Respiratory ___ No Problems	Shortness of breath Wheezing Pain with breathing Chronic cough Coughing up blood	Asthma Allergies Bronchitis/ pneumonia Positive TB test History of smoking	Exposure to chemicals Exposure to solvents Exposure to particulates	History of second-hand smoke Other:
Cardiovascular ___ No Problems	High blood pressure Low blood pressure High cholesterol High glucose Chest pain Heaviness in legs Cold hands/feet Varicose veins	Feel heart racing Chest tightness Difficulty breathing at night Palpitations Swelling in ankles Heart fluttering Purple fingers/lips	Irregular heartbeat Heart murmur Dizziness upon standing Exhaustion with minor Exertion Hemorrhoids Spider veins	Calf pain at night Calf pain walking Other:
Gastrointestinal ___ No Problems	Poor appetite Excessive appetite Changes in appetite Excessive thirst Trouble swallowing Stomach pain Nausea/ vomiting Vomiting blood Burping/ belching Abdominal pain Abdominal bloating Gas/flatulence Indigestion Heartburn/ Antacid use	Constipation (<1 stool/day) Stools that are hard to pass Foul-smelling stools Loose stools (break up when hit water) Diarrhea Blood in stools Black tar in stools Mucous in stools Undigested food in Stools Gallbladder disease	Stool shape: One piece Hard little pellets Breaks up when in water Color: Yellow Green Light brown Dark brown Treated for parasites Ulcers Hemorrhoids	Intolerance to specific foods Fatigue after eating Food sensitivity Anal itching Liver disease Other:

Review of Systems (continued)

Circle if the symptom has occurred in the last year.
 Place a check mark if the symptom has occurred in the past.

Neurological ___ No Problems	Fainting Dizziness/vertigo Numbness or tingling Trembling hands Loss of grip strength	Head trauma Poor concentration Memory loss Lack of mental alertness Loss of muscle tone	Muscle weakness Heavy head Heavy extremities	Other:
Urinary ___ No Problems	Frequent urination Urinate < 3 times/day Can't hold urine Urination with cough or sneeze Dripping after urination	Light yellow urine Yellow urine Yellow dark urine Red urine Cloudy urine Strong smelling urine	Kidney or bladder infections Urination at night Painful/burning Urination Bed-wetting	Other:
Musculoskeletal ___ No Problems	Pain in: Arms Shoulders Upper back Lower back Legs Hips Neck Hands Feet	Painful bones Tight shoulder muscles Swollen knees/elbows Numbness Tingling Burning Spasms/cramps Morning stiffness Arthritis Herniated/slipped disk	Chronic pain Loss of height Unable to sit straight Activities limited due to pain Tendonitis Osteoporosis Broken bone	Other:
Women Only ___ No Problems	Age of first menses: Length of period: Length of cycle: Date of last menses: Heaviest flow day: # of pads/tampons on Heaviest day: Abnormal Pap?	# of pregnancies: # of live births: Currently sexually active? Yes ___ No ___ Which gender are you sexually active with? Men ___ Women ___ Both ___ Type of birth control: Type of STD control: Condoms Monogamy Other	Spotting between periods Clots with period Menstrual cramps Weight gain with period PMS Irritability Moodiness Crave sweets Tendency to cry Bloating/ swelling Breast tenderness Low back pain Fatigue with period Missed periods Irregular periods Difficulty conceiving Lack of sexual drive	Vaginal itching Vaginal discharge Vaginal odor Yeast infections Vaginal mucosa dry Painful intercourse/ masturbation History of STDs? Yes / No Have been tested for STDs? Yes / No Uterine cyst/fibroids Hysterectomy Use of birth control pill for greater than 10 years
Women Only	Monthly breast self-exam Yes / No Fibrous breast Breast feed your child Breast implants History of mammograms Abnormal mammogram Nipple discharge	Hot flashes Vaginal dryness Changes in cycle Moodiness Brain fog Menopause Age of menopause: Use of hormone replacement	Other:	
Men Only ___ No Problems	Sense of full bladder Difficulty urinating Burning/pain with urination Wake up to urinate Dripping after urination Increased straining with urination	Discharge from penis Sore on penis History of STDs? Yes / No Have been tested for STDs? Yes No Premature ejaculation Painful ejaculation Erectile dysfunction Infertility Lack of sexual drive Sexual difficulties	Testicular lump Testicular pain Breast lump Monthly testicular/breast exam History of prostatitis Enlarged prostate Have had a prostate exam Have had a PSA Prostate cancer Pain/cold in genital area Hernias	Currently sexually active? Yes / No Which gender are you sexually active with? Men / Women / Both Type of birth control: Type of STD control: Condoms Monogamy Other:

Preventive Health Care

Please indicate the last time you had the following exam.

Preventive Care	Date	Results	Doctor	Phone Number
Physical exam				
Blood pressure				
Blood tests				
Urinalysis				
Stool tests				
Rectal exam				
Colonoscopy				
Skin exam				
Dental exam				
PAP/Pelvic exam				
Mammogram				
Bone density test				
Testicular exam				
PSA/prostate exam				
STD tests				
Chest x-ray				
EKG				
Tetanus booster				
TB skin test				
Vision/Glaucoma exam				
Hearing exam				
Monthly breast self examination				

Activities of Daily Living

Activity	How often per day, week, month, always, never	Activity	How often per day, week, month, always, never	Activity	How often per day, week, month, always, never
Coffee/ black tea		# of meals per day		# of hours of sleep	
Soda		# of 8 oz glasses of water per day		Once up, feel rested	
Tobacco		Eat red meat		Difficulty going to sleep	
Alcohol		Eat chicken		Difficulty staying asleep	
Recreational drugs		Eat fish		Difficulty waking up	
Physical activity/ exercise		Eat fresh vegetables		Take time for yourself	
Drive with seat belt		Eat fruit		Watch TV	
Brush teeth		Eat dairy products		Participate in friendships, community, support groups	
Dental floss		Eat refined wheat		# hours in a car or bus	
Wear sunscreen		Eat products with sugar added		Sexually active with partner	
Exposed to chemicals		Eat whole grains		Form of contraception	
# hours per week at work		# of bowel movements		Number of sexual partners	
# of vacations per year		# of times urinate		Does a condition limit your activities?	

Family History

Relation	Age	State of health	Age of Death	Cause of Death	Condition	Do any of your blood relations have any of the following diseases?
Mother					Arthritis, gout	
Stepmother					Asthma	
Father					Bleeding tendency	
Stepfather					Cancer	
Brothers/stepbrothers					Chemical dependency/ alcoholism	
					Diabetes	
Sisters/stepsisters					Epilepsy	
					Heart disease/ strokes	
					High blood pressure	
Children/stepchildren					High cholesterol	
					Hearing loss	
					Kidney disease	
					Mental health issues	
					Osteoporosis	
					Tuberculosis	
					Suicide	
					Other inheritable Conditions	

Who is filling out this questionnaire? Self Spouse Parent Other: _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature _____ Date _____

Physician's Signature (upon review) _____ Date _____

Jonathan A. Truhlar, D.C.

OFFICE USE ONLY

PHYSICIAN'S NOTES:

HISTORY IS TAKEN FROM ^a PATIENT ^a SPOUSE ^a PARENT ^a OTHER: _____

INFORMATION IS ^a RELIABLE ^a NOT RELIABLE ^a SATISFACTORY ^a NOT SATISFACTORY.

ADDITIONAL COMMENT ^a NO ^a YES _____

