Core Chiropractic & Wellness
Health History Questionnaire

Did your symptoms developed from: ☐ Job Related Injury ☐ Auto Accident ☐ Other Accident
☐ Illness ☐ Unknown Cause ☐ Gradual Onset ☐ Other
Date Occurred (if known):

Symptoms have persisted for # _____Hour(s) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

Please describe your present condition/symptoms:

Symptoms/Complaints: Come & Go ☐ Are Constant ☐ Both ☐

Activities of Daily Living

Please circle the appropriate letter if the activity A=aggravates, R= relieves or has N=no effect on your condition

A	R	N	Bending	A	R	N	Getting Up	A	R	N	Carrying Objects	A	R	N	Bathing
A	R	N	Lifting	A	R	N	Lying Down	A	R	N	Get In/Out of car	A	R	N	Coughing
A	R	N	Leaning	A	R	N	Reaching	A	R	N	Yard Work	A	R	N	Job Duties
A	R	N	Twisting	A	R	N	Stooping	A	R	N	Going up Stairs	A	R	N	House Work
A	R	N	Sitting	A	R	N	Reclining	A	R	N	Doing down stairs	A	R	N	Tying Shoes
A	R	N	Walking	A	R	N	Exercise	A	R	N	Pushing Objects	A	R	N	Dressing
A	R	N	Standing	A	R	N	Squatting	A	R	N	Pulling Objects	A	R	N	Hobbies
A	R	N	Kneeling	A	R	N	Driving	A	R	N	Taking out trash	Other:			

Describe the Location and Symptoms of Current Complaints

Please use all Letters that apply (C, T, L, UE, LE, O) to indicate symptoms experienced in that region
C=Neck, **T**=upper and mid back, **L**= Low back, **UE**= upper extremity, **LE**=lower extremity, **O**=other

Ex. C, LE	Achy	**T, L**	Dull	**UE, O**	sharp		
C, T, L, UE, LE, O	Symptom	C, T, L, UE, LE, O	Symptom	C, T, L, UE, LE, O	Symptom	C, T, L, UE, LE, O	Symptom
	Achy		Dull		Pounding		Squeezing
	Burning		Electric		"Pressure-like"		Stinging
	Catching		Fullness		Ringing		Stabbing
	Constricting		Grabbing		Sharp		Tense
	Cramping		Nagging		Shooting		Tingling
	Cutting		Numbing		Spasms		Throbbing
	Deep		Pinching		Stiff		Weak

Does pain wake you up at night? No ☐ Yes ☐ if so, how many hours of sleep do you get? _____
Are your symptoms worse during certain times of the day? No ☐ Yes ☐ if so, When? _____

Past Medical History

Have You Ever?	Y	N	When	Please Explain
Broken Bones				
Been in an Auto Accident				
Been Hospitalized				
Had Sprains/Strains				

Patient Signature: _____ Date:__

Patient:

Additional Symptoms You May Be Experiencing or Have Had Within The Last Two Months: (check all that apply)

Condition	Y	N	Condition	Y	N	Condition	Y	N
Back or Neck Pain			Asthma			Heart Attack		
Muscle Weakness			Bronchitis			High Blood Pressure		
Pain in Hips			Shortness of Breath			Stroke		
Depression			Emphysema - COPD			Seizures		
Anxiety			Pneumonia			Chest Pain - Angina		
Constipation			Sore Throat			Diabetes		
Diarrhea			Cough			Skin Problems		
Stomach Ulcers			Thyroid Problems			Kidney Disease		
Heart Burn			Leg Swelling/Edema			Cancer		
Abdominal Pain			Weight Gain/Loss			Fever/Night Sweats		
			Cold Feet/Hands			Stress		
			Arthritis			Bowel/Bladder Issues		

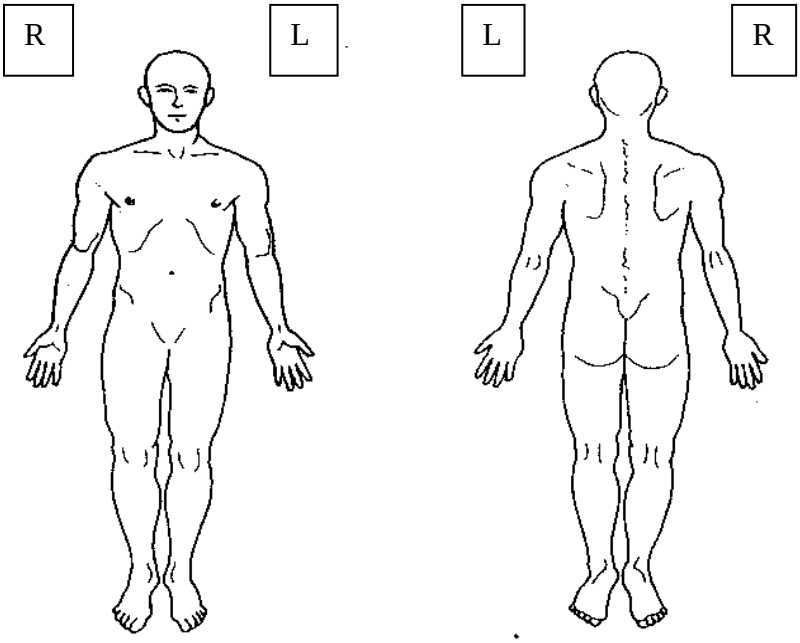
Family History	Father	Mother	Sibling	Paternal GF	Paternal GM	Maternal GF	Maternal GM	
Living								
Deceased								
Diabetes								
Hypertension								
Heart Disease								
Cancer								
Stroke								
Thyroid Disease								
High Cholesterol								
Lung Disease								
COPD/Emphysema								
Seizures								

Patient Signature: Date:

Spouse's or guardian's Signature: Date:

Patient:				
Social History	**Y**	**N**		
Tobacco			Packs Per Day?	
Alcohol			How Often?	
Exercise			How Often? Type?	
Female History	Are You Pregnant Y ☐ N ☐		Date of Last Menstrual Cycle?	
Allergies	Medications/Drug Allergies			
	Seasonal			

Current Symptoms	
Please use the following letters to indicate the TYPE and LOCATION of your symptoms on the Diagram	
A=Ache	N=Numbness
B=Burning	S=Sharp
O=Other:	



Patient Signature: _____ Date:_____

Spouse's or guardian's Signature _____Date_____

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Current Medication List

Include Prescribed, Over the Counter, Vitamins and Supplements

Medication	Dosage/Frequency	Date Started	Physician

Surgical History

Surgery	Date	Doctor/Facility

Patient Signature: _____ Date:_____

Spouse's or guardian's Signature _____Date:_____