

# WASHINGTON MEDICAL GROUP, P.C.

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## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### SECTION 1: WHY ARE YOU HERE?

- 1.1. What is your primary chiropractic problem today? Check one only.  
 Pain  Numbness  Tingling  Weakness  Swelling  Stiffness
- 1.2. Where is your **primary** chiropractic problem located? Check only one.  
 Right side  Left side  Both sides
- 1.3. Are you right-handed or left handed? Check one only.  
 Right handed  Left handed
- 1.4. What body part is involved with your **primary** chiropractic problem? Please choose all that apply.
- |                                        |                                      |                                   |                                   |                                       |
|----------------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Neck          | <input type="checkbox"/> Upper Back  | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Arm      | <input type="checkbox"/> Elbow        |
| <input type="checkbox"/> Forearm       | <input type="checkbox"/> Wrist       | <input type="checkbox"/> Hand     | <input type="checkbox"/> Thumb    | <input type="checkbox"/> Index Finger |
| <input type="checkbox"/> Middle Finger | <input type="checkbox"/> Ring Finger | <input type="checkbox"/> Pinky    | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Low Back     |
| <input type="checkbox"/> Pelvis        | <input type="checkbox"/> Hip         | <input type="checkbox"/> Buttock  | <input type="checkbox"/> Thigh    | <input type="checkbox"/> Knee         |
| <input type="checkbox"/> Lower Leg     | <input type="checkbox"/> Calf        | <input type="checkbox"/> Ankle    | <input type="checkbox"/> Foot     | <input type="checkbox"/> Toe          |
- 1.5. Have you received Physical Therapy recently for **this problem**?  Yes  No
- 1.6. Have you received Chiropractic Therapy recently for **this problem**?  Yes  No
- 1.7. How did the symptoms begin?  Unknown  Gradually  Suddenly, without injury
- After an injury      Date of injury: \_\_\_\_\_
- After an accident      Date of accident: \_\_\_\_\_
- 1.8. How did the injury occur? (Please print clearly)
- 
- 1.9. Was the injury work related?  Yes  No
- 1.10. Was the injury due to a motor vehicle accident?
- No  Yes If yes, date of accident: \_\_\_\_\_

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Were you the:  Driver  Passenger      Were you wearing a seat belt?  No  Yes

1.11. How long have the symptoms been present?  Not Sure

Weeks       1    2    3    4    5    6    7    8    9    10

Months       1    2    3    4    5    6    7    8    9    10

Years       1    2    3    4    5    6    7    8    9    10

1.12. How severe are the symptoms?

Mild    Moderate    Severe

1.13. Are your current symptoms worsening, improving or unchanged?

Worsening    Improving    Unchanged

1.14. On a scale from 0-10, with 10 being the highest, how would you rate the severity of your pain?

Left side:       0    1    2    3    4    5    6    7    8    9    10

Right side:       0    1    2    3    4    5    6    7    8    9    10

1.15. What other symptoms are you experiencing? Check all that apply.

Chills                       Fever                       Numbness                       Instability  
 Tingling                       Weakness                       Swelling                       Stiffness  
 Altered Gait                       Pain awakening from sleep                       Loss of bowel control                       Headaches  
 Radiation of pain                       Loss of bladder control

1.16. How can the problem be characterized? Check all that apply.

Intermittent                       Constant                       Burning                       Aching                       Pins and Needles  
 Sharp                       Stabbing                       Throbbing                       Cramping                       Dull

1.17. Are the symptoms better during the day or night? Check all that apply.

Day    Night

1.18. The symptoms improve with: Check all that apply:

Rest    Activity    Medication    Ice/cold    Heat    Walking

1.19. The symptoms are made worse with: Check all that apply:

Rest    Activity    Sitting    Ice/cold    Heat    Walking

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1.20. If you have a back or neck problem, please indicate the effect of pain for each of the following (check one only for each):

- a. Sitting:                                     Increases     Decreases     No change
- b. Standing:                                    Increases     Decreases     No change
- c. Walking with grocery cart:            Increases     Decreases     No change
- d. Lifting:                                      Increases     Decreases     No change
- e. Twisting:                                    Increases     Decreases     No change
- f. Rising from sitting:                      Increases     Decreases     No change
- g. Bending Forward:                        Increases     Decreases     No change
- h. Bending Backward:                      Increases     Decreases     No change
- i. Walking:                                     Increases     Decreases     No change
- j. Lying on your back:                      Increases     Decreases     No change
- k. Lying on your stomach:                Increases     Decreases     No change
- l. Driving:                                      Increases     Decreases     No change
- m. Coughing/Sneezing:                    Increases     Decreases     No change

1.21. What pain medications are you taking for this problem? Check all that apply:  None

- Advil     Aleve     Bextra     Celebrex     Codeine     Lodine  
 Motrin     Naprosyn     Tylenol     Tylox     Percocet     Vicodin  
 Voltare     Other: \_\_\_\_\_

## SECTION 2: YOUR MEDICAL HISTORY

2.1. Are you currently taking other medications?  No  Yes If yes, please list below:

Name of Drug	Strength	Frequency Taken

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2.2. Do you have any Allergies or Reactions?  No  Yes If yes, please list below:

Medication	Type of Reaction

2.3. Have you had any surgeries?  No  Yes If yes, please list below:

Year	Reason	Hospital

## SECTION 3: SOCIAL, PERSONAL & FAMILY HISTORY

3.1. Do you smoke tobacco?  No  Yes

If yes, how many packs per day?  Less than one  One  Two  Three or more

If yes, how many years?  1-5  6-10  11-20  More than 20

3.2. Do you drink alcohol?  No  Yes

If yes, how frequent?  Rarely  Socially (2-3 per week)  Daily

3.3. Do you live alone?  No  Yes

3.4. Are there stairs in your home?  No  Yes

3.5. What is your marital status?  Single  Married  Divorced  Separated  Widowed  N/A

3.6. What is your work status?  Working  Paid Leave  Unemployed  Homemaker  Student  
 Retired (not due to health reasons)  Disabled and /or Retired (due to back or neck problems)  
 Disabled (due to health: not related to back or neck problems)  Other, list below:

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3.7. What is your father's health status? (Choose only one):  Living  Deceased  Unknown

3.8. Please indicate your father's medical conditions (Choose all that apply):

Stroke  Heart Disease  Diabetes  Cancer  TB  Arthritis  High Blood Pressure

3.9. What is your mother's health status? (Choose only one):  Living  Deceased  Unknown

3.10. Please indicate your mother's medical conditions. (Choose all that apply):

Stroke  Heart Disease  Diabetes  Cancer  TB  Arthritis  High Blood Pressure

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3.11. What is the health status of your siblings? (Choose only one):  Living  Deceased  Unknown

3.12. Please indicate your sibling's medical condition. (Choose all that apply):

Stroke  Heart Disease  Diabetes  Cancer  TB  Arthritis  High Blood Pressure

3.13. Indicate all medical conditions you've had in the past:  No significant History

Asthma  BPH/Prostate Disease  Bronchitis  
 COPD  Coronary Artery Disease  Depression  
 Elevated Cholesterol  Fibromyalgia  GERD  
 Obesity  Kidney/Renal Disease  Liver Disease  
 Peripheral Vascular  Osteoarthritis  Osteoporosis  
 Thyroid Disease  Rheumatoid Arthritis  Stomach Ulcers  
 Cancer  Diabetes  Hypertension  
 Gout  Osteomyelitis  Stroke/TIA/CVA

3.14. Check the problems you have had in the last 6 months. Circle all that apply. **NP-No Problems**

a. General	NP	Fevers	Sweats	Weight Gain	Weight loss
		Weight loss unexplained			
b. Eyes, Ears & Nose	NP	Hearing loss	ringing in ears	Vision Changes	
c. Throat & Mouth	NP	Hoarseness	Sore Throat	Trouble Swallowing	
d. Respiratory	NP	Wheezing	Shortness of breath	Cough	
e. Cardiac	NP	Chest pain	Irregular heartbeat	High blood pressure	
		Leg cramps			
f. Gastrointestinal	NP	Diarrhea	Heartburn	Abdominal Pain	
		Nausea	Vomiting		
g. Musculoskeletal	NP	Bone Pain	Other joint pain	Other muscle pain	
h. Skin	NP	Skin ulcers	Rashes	Hives	
i. Neurological	NP	Weakness	Fainting	Loss of coordination	
j. Psychiatric	NP	Depression	Anxiety	Disoriented	
k. Genitourinary	NP	Burning	Discharge	Difficulty urinating	
		Change in frequency			

**Patient's Signature:** \_\_\_\_\_ **Parent or Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Reviewed by:** \_\_\_\_\_