WASHINGTON MEDICAL GROUP, P.C.

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.

___ Neck	___ Upper Back	___ Shoulder	___ Arm	___ Elbow
___ Forearm	___ Wrist	___ Hand	___ Thumb	___ Index Finger
___Middle Finger	___ Ring Finger	___ Pinky	___ Mid Back	___ Low Back
___Pelvis	___ Hip	___ Buttock	___ Thigh	___ Knee
___Lower Leg	___ Calf	___ Ankle	___ Foot	___ 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: ________________

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

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

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:

____

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:**____