

**New/Returning Patient Questionnaire**

*Please take your time to complete this form legibly and thoroughly. The more detailed you are, the more we will be able to help you achieve your health goals.*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Married \_\_Single \_\_Widowed \_\_Divorced \_\_Partnered Children (Ages): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your visit today as a result of a work injury or auto accident? *Please Circle*: Yes or No

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bus. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please choose one for patient related information: 1. Regular mail

 (appointment reminders, billing, etc.) 2. Phone Call or Voicemail

 3. Text Message – Cell # \_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_ initial: \_\_\_\_\_\_

 4. Email

***Please Print Clearly***

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the symptoms or problem that you want us to help you with? Please list:

Have you had chiropractic care or acupuncture before? \_\_\_\_Acupuncture \_\_\_\_Chiropractic \_\_\_\_Both

Please explain the results:

**Your Pain**

Is your health problem a work-related injury? \_\_\_Yes \_\_\_No If “yes” did you report the injury? \_\_\_Yes \_\_\_No

In what position do you sleep? \_\_\_side \_\_\_back \_\_\_front Do you use a pillow? \_\_\_\_Yes \_\_\_No

Did your pain or symptoms come on: \_\_\_gradually \_\_\_suddenly Is it: \_\_\_constant \_\_\_intermittent

What time of the day is the pain the worst: \_\_\_morning \_\_\_afternoon \_\_\_evening \_\_\_night \_\_\_constantly

What makes your pain symptoms worse?

What makes your pain symptoms better?

Please circle those you presently (in recent weeks) have. Underline those you have had in the past.

**General**

Headache

Fever

Chills

Sweats

Fainting

Dizziness

Imbalance

Seizures

Epilepsy

Sleeping difficulties

Sleep apnea

Quality of sleep

Sleep \_\_\_ hrs/night

Feel run-down

Fatigue

Hypoglycemia

Nervousness/anxiety

Panic attacks/phobias

Depression

Mental disorder(s)

Alcohol problem

Drug problems(s)

Diabetes

Neuralgia

Anemia

Cancer

Memory Loss

Scarlet Fever

Typhoid Fever

Rheumatic Fever

Measles

Mumps

Chicken Pox

Weight loss\_\_\_\_lbs

Weight gain\_\_\_\_lbs

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ear, Nose & Throat**

Eye strain/pain

Failing vision

Blurred vision

Glaucoma

Sensitivity to light

Hearing problems

Ear noises

Ear discharge

Sinus infection

Nose bleeds

Nasal obstruction/

drainage

Sore throat

Hoarseness

Loss of Voice

Dental decay

Mouth sores

Gum disease

Teeth grinding

Jaw Pain

Frequent colds

Thyroid condition

Tonsillitis

Enlarged glands

Hay Fever

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin**

Rashes

Skin eruptions

Eczema

Itching

Bruise easily

Dry skin

Boils

Moles

Varicose veins

Sensitive Skin

Hair loss

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory**

Asthma

Pneumonia

Emphysema

Tuberculosis

Bronchitis

Pleurisy

Chronic cough

Spitting phlegm

Spitting blood

Chest Pain

Difficult breathing

Shortness of breath

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular**

Rapid heartbeat

Slow heartbeat

Irregular heartbeat

High blood pressure

Blood clots

Low blood pressure

Pain over heart

Pacemaker

Hardening of arteries

Swelling of ankles

Poor circulation

Stroke/TLA

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Muscle & Joint**

Stiff neck

Backache

Gout

Swollen Joints

Painful Joints

Arthritis

Bursitis

Tendinitis

Muscle or joint weakness

Muscle spasms or cramps

Fibromyalgia

Foot trouble

Spinal curvature

Osteoporosis

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genitourinary**

Frequent urination

Night urination \_\_times

Painful urination

Blood in urine

Pus in urine

Kidney infection or stones

Bed-wetting

Inability to control urine

Prostate trouble

Hernia

Sexually transmitted disease

Sexual dysfunction/

difficulty

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal**

Trouble swallowing

Bad breath

Indigestion/

heartburn

Nausea

Poor appetite

Belching or passing gas

Excessive hunger

Cravings

Eating Disorder

Vomiting of blood

Ulcers

Pain over stomach

Distention of abdomen

Constipation

Diarrhea

Colitis

Appendicitis

Bowel Condition

What aggravates the above?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hemorrhoids (piles)

Intestinal worms

Parasites

Hepatitis

Liver trouble

Gall Bladder trouble

Jaundice

Bad body odor

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Women Only**

PMS (list symptoms)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mood swings/

irritability

Painful menstrual period

Excessive flow

Bleeding between cycles

Irregular cycle

Cramps or backache w/period

Endometriosis

Ovarian cysts

Uterine Fibroids

Abnormal PAP results

Vaginal Discharge

Breast pain/

tenderness

Breast Lumps

Menopausal Symptoms

Hot Flashes

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List surgical procedures or hospitalizations with dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accidents, with or without injury (car accident, slips, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X-ray, MRI, CAT or bone scans (where, when and what was found?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you typically eat for:

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink (with or between meals) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times a day do you have bowel movements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your bowel movements: \_\_\_\_\_loose \_\_\_\_\_hard \_\_\_\_\_difficult to pass \_\_\_\_\_strong-smelling

 \_\_\_\_\_accompanied by gas

What is the typical color: \_\_\_\_blackish \_\_\_\_brown \_\_\_\_clay \_\_\_\_greenish \_\_\_\_\_bloody

For those that apply to you, please list indicated quantities consumed:

Smoke Cigarettes (# per day) \_\_\_\_\_\_\_\_\_\_\_\_\_ Other tobacco (amnt per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wine/Beer (# of glasses per day or week) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hard liquor (oz. per day or week) \_\_\_\_\_\_\_\_\_\_\_\_oz.

Coffee (# of cups per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tea (# of cups per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soda (# of cups/cans per day) \_\_\_\_\_\_caffeinated \_\_\_\_\_non-caffeinated \_\_\_\_\_diet

Sweets (candy, chocolate per week) \_\_\_\_\_\_\_\_\_\_\_\_\_oz.

Water (# of cups per day) \_\_\_\_\_chlorinated \_\_\_\_\_bottled \_\_\_\_filtered

What allergies to foods, drugs or inhalants do you have and how do you react?

Typically how often do you exercise per week? \_\_\_\_ never \_\_\_\_once/twice \_\_\_\_\_daily

**Your Current Mental Health**

On a scale of 0-10 (10 highest), what number do you believe reflects your current level of stress? \_\_\_\_\_\_

Please list the four most significant stress events in your life.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Pain Drawing**

Please place the symbol(s) on the body in the area(s) that best describe(s) the pain or discomfort you are having:

SP= Sharp Pain DP= Dull Pain B=Burning N=Numbness T=Tingling

S=Stabbing A=Ache TH=Throbbing

On a scale of 0 – 10 (0= pain free, 10= constant pain), rate each area of pain:

Neck \_\_\_\_\_\_\_ Mid back \_\_\_\_\_\_ Low back\_\_\_\_\_\_ Shooting pain\_\_\_\_\_\_ Numbness\_\_\_\_\_\_ Other\_\_\_\_\_\_



In which of the following areas would you like our support? (Check all that apply, circle the ones that’s most important)

\_\_\_\_ Have more energy

\_\_\_\_ Be happier

\_\_\_\_ Monitor my body’s aging

\_\_\_\_ Be less tired after lunch

\_\_\_\_ Not need so many drugs

\_\_\_\_ Be stronger

\_\_\_\_ Get rid of allergies

\_\_\_\_ Be more flexible

\_\_\_\_ Reduce my risk of degenerative disease

\_\_ \_\_Improve my skin quality

\_\_\_\_ Slow accelerated aging

\_\_\_\_ Sleep better

\_\_\_\_ Be less depressed

\_\_\_\_ Maintain a healthier life longer

\_\_\_\_ Get less colds/flu

\_\_\_\_ Be less moody

\_\_\_\_ Reduce body fat

\_\_\_\_ Have more sex drive

\_\_\_\_ Improve my memory

\_\_\_\_ Learn how to reduce stress

Please list any and all drugs/medications (over –the-counter/prescription), which you are presently taking or have taken. When did you start/stop their use? Dosage?

What supplements, vitamins and/or herbs do you take?

**Medical History**

Is there a history of the following conditions in your family:

\_\_\_\_ Heart disease

\_\_\_\_ High blood pressure

\_\_\_\_ Circulatory conditions

\_\_\_\_ Cancer

\_\_\_\_ Diabetes

\_\_\_\_ Osteoarthritis

\_\_\_\_ Rheumatoid arthritis

\_\_\_\_ Multiple sclerosis

\_\_\_\_ Muscular dystrophy

\_\_\_\_ Mental illness

\_\_\_\_ Autoimmune disorders

\_\_\_\_ Asthma

\_\_\_\_ Allergies

\_\_\_\_ Psoriasis

\_\_\_\_ Eczema

\_\_\_\_ Alcoholism

\_\_\_\_ Drug Abuse

Any other conditions that are pertinent to your present state of health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***This questionnaire is strictly confidential between you and the Park View Health & Wellness Center professional. Please go back over your responses and consider their accuracy. Thank you!***

**I authorize the Park View Health & Wellness Center’s practitioners and staff to perform examinations and treatment deemed necessary by my provider for my condition.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**