

Health Questionnaire

Patient Name _____ Date _____

1. Describe your condition. _____

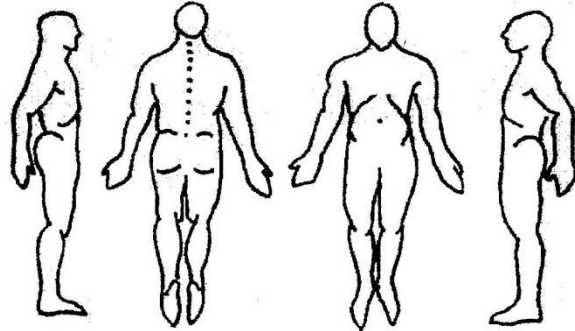
a. When did your dysfunction begin? _____

b. How did your dysfunction begin? _____

2. How often do you experience your dysfunction?

(Circle one)

- 1. Constantly (76-100% of the day)
- 2. Frequently (51-75% of the day)
- 3. Occasionally (26-50% of the day)
- 4. Intermittently (0-25% of the day)



3. What describes the nature of your dysfunction?

- 1. Sharp
- 2. Dull ache
- 3. Numb
- 4. Shooting
- 5. Burning
- 6. Tingling
- 7. Stiffness
- 8. Loss of motion
- 9. Weakness

4. How is your dysfunction changing?

- 1. Getting better
- 2. Not changing
- 3. Getting Worse

5. Indicate the average intensity of your dysfunction- None

Unbearable

During the last 24 hours	0	1	2	3	4	5	6	7	8	9	10
During the last week	0	1	2	3	4	5	6	7	8	9	10

6. How much has your dysfunction interfered with your normal work (includes work outside the home and housework) or social activities?

- 1. Not at all
- 2. A little bit
- 3. Moderately
- 4. Quite a bit
- 5. Extremely

7. In general would you say your overall health is

- 1. Excellent
- 2. Very good
- 3. Good
- 4. Fair
- 5. Poor

8. Who have you seen for your condition?

- 1. No one
- 2. Chiropractor
- 3. Medical doctor
- 4. Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

- 1. X-rays date _____
- 2. CT scan date _____
- 3. MRI date _____
- 4. Other date _____

9. Have you had a similar condition in the past? 1. Yes 2. No

a. If you received treatment in the past for the same or similar condition who did you see?

- 1. This office
- 2. Chiropractor
- 3. Medical Doctor
- 4. Physical Therapist
- 5. Other

10. What is your occupation? 1. Professional 2. White Collar/Adm. 3. Tradesperson 4. Laborer

- 5. Homemaker
- 6. FT Student
- 7. Retired
- 8. Other

a. If you are not retired, a homemaker or a student what is your current work status?

- 1. Full-time
- 2. Part-time
- 3. Self-employed
- 4. Unemployed
- 5. Off work
- 6. Other

Patient Signature _____ Date _____