Health Questionnaire

-Please Print-

Name		Phone	Date
Email address		Work phone	
Complete address (include city, state and zip)		Date of Birth	Age
Please Circle One Married Single Widowed Divorced	Number of Children	Social Security #	
	Occupation		
What is your major complaint?			
How long has it been bothering you?		Has it bothered you before?	
Referred by:	Have you had chiropractic care before? Yes/No If yes when?		
Are you on Medicare? Y/N If yes #	Are you on Medicaid? Y/N, If yes #	Do you have health insurance? Y/N If yes, company:	
Please indicate if you are here for care because of a recent:			
On the job injury Y/N Date:	An auto accident Y/N Date:	Home injury Y/N Approx. Date:	
Have you ever had any **falls**, **auto accidents**, or **injuries**? Yes please explain No	Month, Year	Type of Accident	Describe injury
Have you ever had any surgery? Yes please explain No	Month, Year	Type of Surgery	Comments
Are you presently taking medication or vitamins? Yes please list No	Name of Drug	Doses per day	Length
Please describe your occupation			
List any sport/exercise programs			

Please check any of the following that give you difficulty

☐ Headaches	☐ Fainting	☐ Shortness of breath	☐ Ulcers
☐ Shooting head pains	☐ Loss of balance	☐ Mid back pain	☐ Numbness in legs or feet
☐ Sinus Trouble	☐ Ringing in ears	☐ Heart attacks	☐ Constipation
☐ Loss of smell	☐ Blurred vision	☐ High blood pressure	☐ Kidney trouble
☐ Allergies	☐ Lights bother eyes	☐ Low blood pressure	☐ Menstrual cramps and pain
☐ Hayfever	☐ Neck pain	☐ Anemia	☐ Menstrual irregularity
☐ Asthma	☐ Muscle spasms in neck	☐ Stomach trouble	☐ Diabetes
☐ Loss of taste	☐ Grinding in neck	☐ Nerves & nerveousness	☐ Cancer
☐ Inflamation of the throat	☐ Tightness of shoulders & arms	☐ Inner tension	☐ Sleeping problems
☐ Thyroid trouble	☐ Pain in shoulders & arms	☐ Irritability	☐ Painful joints
☐ Twitching of face	☐ Pins & needles in arms & hands	☐ Gall bladder trouble	☐ Swollen joints
☐ Loss of memory	☐ Cold hands	☐ Indigestion	☐ Pins & needles in legs
☐ Fatique	☐ Numbness in arms/hands	☐ Intestinal gas	☐ Swollen ankles
☐ Depression	☐ Cold fingers	☐ Low back pain	☐ Cold feet
☐ Dizziness			☐ Pains in legs and feet

Do any of your children have any of the following:	(Name & Age)	Do any of your blood relatives have any of the following:	If yes, what relation
Headaches	Yes/No_____		
Allergies	Yes/No_____	Diabetes	Yes/No_____
Ear infection	Yes/No_____	Cancer	Yes/No_____
Frequent colds	Yes/No_____	Stroke	Yes/No_____
Asthma	Yes/No_____	Heart Problems	Yes/No_____
Constant Irritability	Yes/No_____	Scoliosis	Yes/No_____
Constipation	Yes/No_____	Back Problems	Yes/No_____
Growing pains	Yes/No_____	Headaches	Yes/No_____
Hyper Kinetic	Yes/No_____	Ulcers	Yes/No_____
Bloody nose	Yes/No_____		
Scoliosis	Yes/No_____		
Bedwetting	Yes/No_____		
Have all your children had a scoliosis exam by a chiropractor? Yes or No		Have any of your relatives been examined by a chiropractor? Yes or No	

Do any of the people you work with or live with have the same health problems as you? Yes/No

Please explain

I agree and understand that if for some reason my insurance company denies payment I will be held responsible. I also give Dr. Stephen M. Upchurch permission to treat me under Chiropractic care.

Signature _____ Date _____