Pinetree Family Chiropractic • 106 Lafayette St. • Yarmouth, ME 04096 • 207.846.9292 (p) • 207.846.9290 (f)

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

_____

_____

_____

List any accidents, injuries, surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

_____

_____

_____

_____

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

Do you exercise? □ Yes □ No Hours per week _____What activity(s)? _____

_____

Are you dieting? □ Yes □ No Since:_____ Do you smoke? □ Yes □ No _____packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? _____

Date of last menstrual period: _____

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Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

_____

_____

Have you experienced these symptoms in the past?_____

_____

_____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? ____Yes ____ No Who referred you to us?_____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

_____

_____

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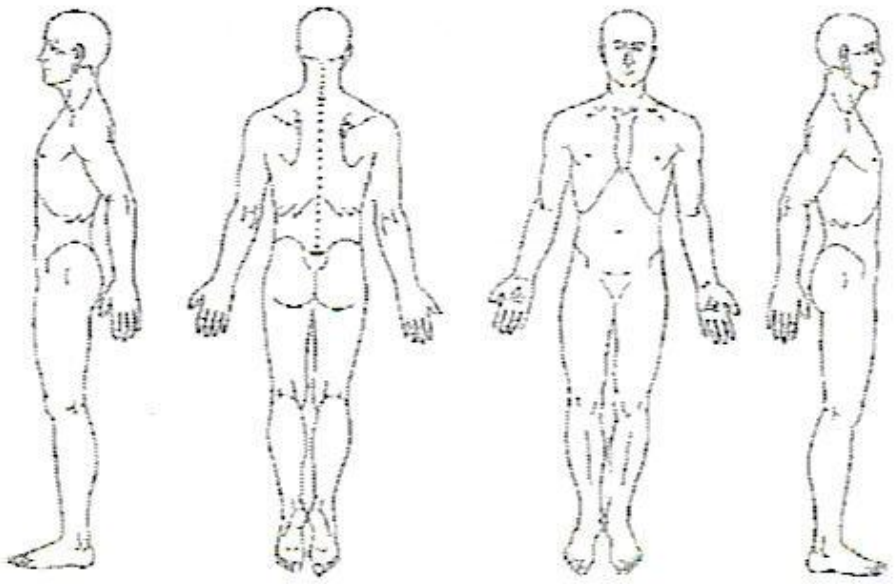
Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain
○	○	Headache	○	○	Migraines	○	○	Digestive Problems

Additional comments you would like the doctor to know: _____

_____

_____

_____

Patient's signature: _____ **Date:** _____

Infants, Children and/or Postpartum Mothers:

Prenatal:

Mother's health status before and during pregnancy: _____

Weeks gestation at birth: _____ First pregnancy? Y / N

Mother's history of drug and alcohol use before and during pregnancy? (incl prescriptions)

_____

Any complications or problems with pregnancy or birth? _____

_____

Delivery:

Location: (home, hospital, birth center, etc): _____

Drugs used during birth: _____

Membranes artificially ruptured? Y / N Episiotomy performed? Y / N

Duration of delivery: _____ Spontaneous / Induced

Mother's position during birth: _____

Presentation at birth: (head first, breech, sunny side up, etc) _____

Any interventions: (forceps, vacuum, Cesarean, etc) _____

Did mother feel birth was excessively traumatic? Y / N

Neonatal:

Child given directly to mother following birth? Y / N If no, explain _____

Infant wakeful and responsive at birth? Y / N Jaundice? Y / N

Infant feed spontaneously? Y / N

Mother's health status postpartum? _____

The first months:

Breast fed / Bottle fed / Both Infant regularly rest with head turned, extended or tilted? Y / N

Any feeding/latching/digestion problems? _____

Child's sleep pattern: _____

How often does child wake up at night? _____ …cry at night? _____

Sleeping position: (stomach, back, side, rotates, etc) _____

Problem breast-feeding on one side? _____

Problem breast-feeding in general? _____

Signs of colic? _____

Normal facial movements/symmetry? _____

Hypersensitivity of neck region? _____

Age weaned: _____ Which foods used? _____

Age infant gained: head control _____, sit up _____, roll over _____, walk _____, other _____

General Health: (Circle if yes)

Headaches	Mouth often open	Language problems
Abnormal posture	Looks only to one side	Moves only one arm/leg
Abnormal movement	Poor concentration	Poor social integration
Face smaller on one side	Back of head flat on one side	Bald spot on back of head
Slow sensory motor development		Asymmetry visible immediately after birth
Asymmetry noted later in development		

Any other information you would like the doctor to know? _____

_____

_____

_____

Signature of Patient, Parent or Guardian _____Date _____