MEKHAEL CHIROPRACTIC
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Health Questionnaire

Current health condition:

- Where is your pain? list if more than one area: _____

- When did this condition begin? _____

- Did you get injured /fall/have an accident prior to this pain? _____

- Are you getting better/ worse / same

- Have you had this condition in the past? _____

- How often do you experience these symptoms? circle one

Constantly (76-100%) Frequently (51-75%)

Occasionally (26-50%) Intermittently (0-25%)

- Describe the nature of your symptoms? circle all that applies

Sharp Dull Numb Burning Shooting
Tingling Radiating pain Tightness Stabbing Throbbing
Other

- Please rate your pain on a scale of 1-10 (0=No pain, 10=Excruciating pain): _____

- Activities Aggravates your condition? (Walking, Running etc.) : _____

- What makes you feel better? (Ice, Heat, Massage, etc): _____

- Other doctors seen for this condition: _____

- Current medications: _____

- Please list anything you maybe allergic to:

-Do you take any supplements or vitamins? Yes/ No

-Do you Exercise? Yes/No

-Do you Smoke? Yes/No

-Family medical history:

-Females only: Are you pregnant? Yes/No Date of last menstural cycle?
Are you taking Birth control? Yes/No Are you Nursing? Yes/No

Do you have or ever had any of the following diseases or conditions?

Y N Heart attack/Stroke
Y N Heart defect
Y N Alcohol /Drug Abuse
Y N HIV/ AIDS
Y N High blood pressure
Y N Diabetes
Y N Tuberculosis
Y N Fainting/ seizures /Epilepsy
Y N Heart surgery/ Pacemaker
Y N Mitral Valve prolapse
Y N Venereal disease
Y N Shingles
Y N Emphysema
Y N Psychiatric problems
Y N Kidney problems
Y N Headaches/Migraines

Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer/ Chemotherapy
Y N Anemia
Y N Rheumatic fever
Y N Ulcer/ Colitis
Y N Asthma
Y N Arthritis
Y N Sinus problems
Y N Difficulty breathing
Y N Artificial bones/ joints
Y N Glaucoma
Y N Frequent Neck pain
Y N Mid back pain
Y N Lower Back pain

Past medical history:

Have you have previous Chiropractic care? Yes/No If so, when _____

Was it a positive experience? _____

Prior surgeries (procedures and dates of:) _____

Major accidents/ Falls: _____

Prior & current illness(es), even if apparently unrelated to current condition:

Patient Name: _____

Patient Signature: _____

Date: _____