Find the Balance
Chiropractic & Wellness Center
www.757chiropractic.com

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Virginia Beach, VA 23455
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# HEALTH QUESTIONNAIRE

## Personal Information

Full name _____Name you wish to be called_____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail: _____

Date of birth ____/____/____ Gender: M / F

Insurance Company: _____

Occupation: _____Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

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## Primary Concern

What brings you to my office?

_____

_____

_____

Date of original condition: _____ Date of most recent occurrence: _____

Was there an event that created the condition?_____

_____

Have you had this or similar conditions in the past?_____

What makes it better? _____Worse? _____

Is the condition getting worse? _____Constant? _____

Worse at a certain time of day?_____

Is this condition interfering with: Work? _____Sleep? _____ Activity? _____Other? _____

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

_____

_____

_____

# Health History

List other current health issues & problems:_____

_____

_____

_____

List other practitioners seen, treatments, self-care activities, and results: _____

_____

_____

_____

List illness you have had not previously mentioned, if any:_____

_____

List all surgeries you have had, with dates and results: _____

_____

_____

Have you ever been in an accident or seriously injured? (if so, please describe)_____

_____

_____

Do you have any dental or TMJ problems? Y N (if so, please describe)

_____

Have you had your wisdom teeth or other teeth removed? Y N *Have you ever had a root canal? Y N

(if yes note which teeth) _____

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking (please bring actual bottles w/pills in with you to your appointment): _____

_____

_____

_____

List all medications and other substances (i.e.: foods) to which you are allergic:

_____

_____

_____

# Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother_____ Children_____

Grandparents _____ Brothers _____ Sisters_____

# General

*Describe your use of: Cigarettes/Tobacco _____Alcohol _____Other drugs_____

*Describe your present exercise habits including frequency per week, duration, and heart rate: _____

_____

_____

* How many hours per night do you sleep? ____ * Do you fall right asleep? Y N * Do you wake up feeling refreshed? Y N

* Do you sleep through the night without awaking? Y N * Do you remember your dreams? Y N

* Do you snore? Y N *Do you have night sweats? Y N * Do you have nightmares? Y N

* Do you grind your teeth at night (bruxism)? Y N * Do you have restless legs (RLS)? Y N

*When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

*Cholesterol or other blood tests _____

* Prostate Exam _____*Other_____

# Pain Questionnaire

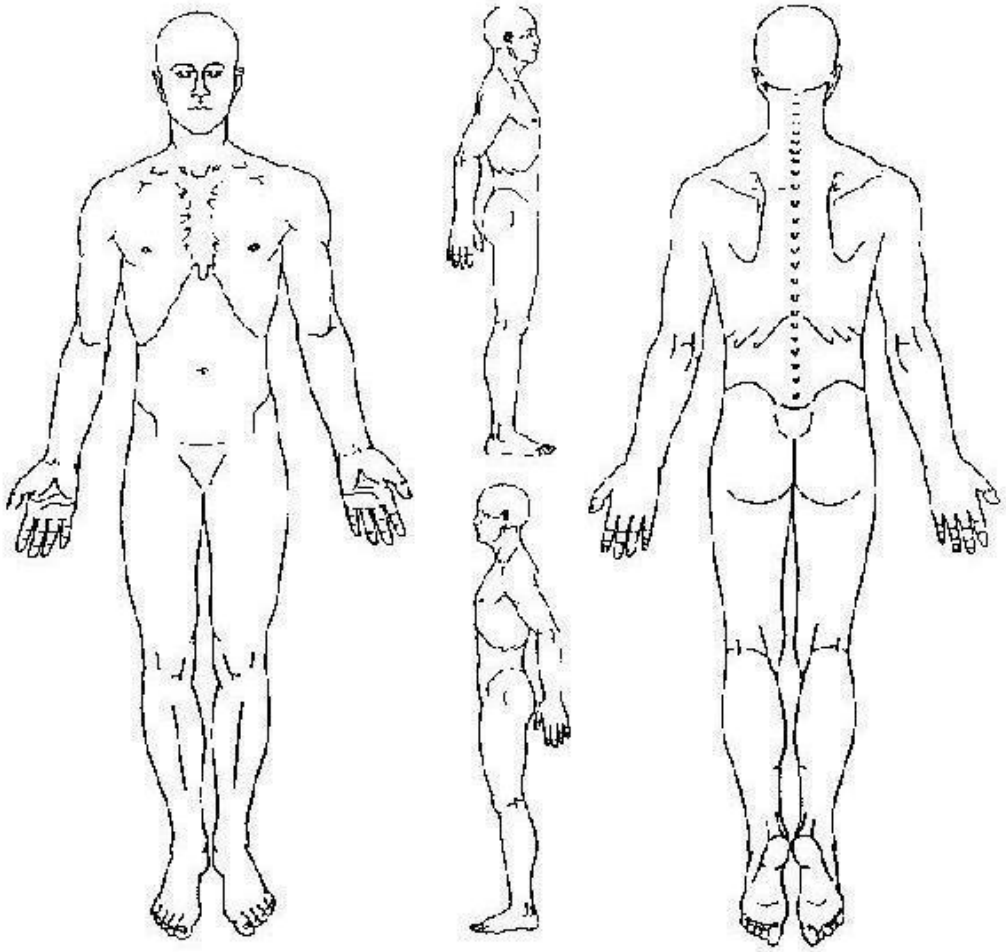
(Skip to the next section if you are not currently experiencing pain.)

**Please place a single vertical line through the scale below at the point that best describes your pain.**
**(0 is no pain, 10 is the worst pain imaginable)**

**0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10**

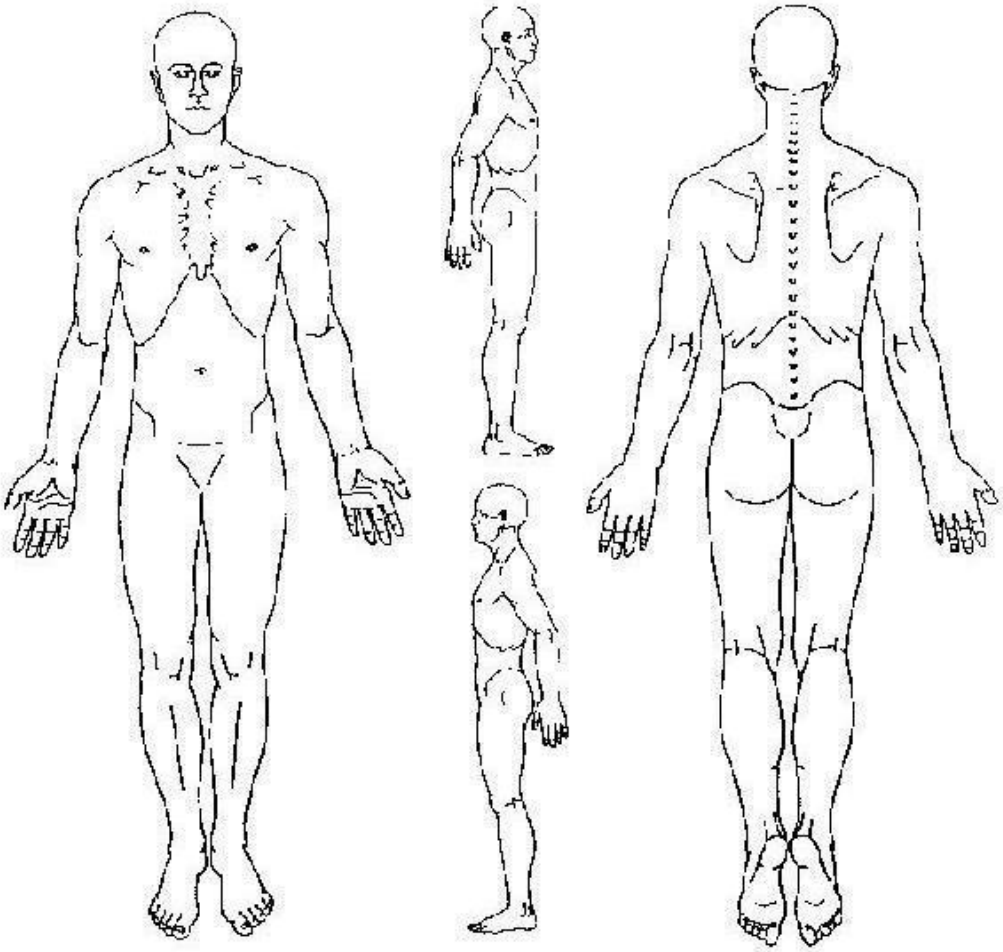
**Place the letters listed below on the diagrams to indicate the type and location of your current sensations.**

**A = Ache B=Burning N=Numbness O=Other P=Pins & Needles S=Stabbing T=Throbbing**



# History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



# SYMPTOM SURVEY

Circle the symptom if you are currently experiencing it or it is a common occurrence. Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

GENERAL

□ Low energy-fatigue
□ Weakness
□ Fever-Chills
□ Headaches
□ Lack of Sleep
□ Reduced Mental Acuity

SKIN

□ Dry skin
□ Itching
□ Varicose veins
□ Cold or canker sores/fever blisters
□ Boils
□Hives
□Rashes
□ Sores
□ Change in your skin/nails

EYES

□ Cataracts/Glaucoma
□ Eye pain
□ Double vision
□ Far or near sightedness
□ Flashing lights
□ Spots, specks, or floaters

EARS

□ Ear Discharge/Excessive Wax
□ Earaches or Infections
□ Hearing Loss
□ Ringing/Tinnitus
□Vertigo/dizziness

NOSE/SINUS

□ Sinus congestion
□ Frequent colds/infections
□ Nosebleeds

NECK

□ Goiter
□ Lumps
□ Pain/Stiffness
□ Swollen Glands

RESPIRATORY

□ Asthma
□ Bronchitis
□ Cough
□ Pneumonia
□ Tend to Hold Breath
□ Wheezing
□ Sputum
□ Trouble Breathing w/Exercise

CARDIAC/VASCULAR

□ Arrhythmia
□ Chest Pain
□ Heart Trouble
□ Murmur
□ High Blood Pressure
□ Palpitations
□ Shortness of Breath
□ Swollen Feet or Lower Legs
□ Racing or Pounding Heart
□ Blood Clots
□ Leg Cramps
□ Poor Circulation

MOUTH/THROAT

□ Dentures
□ Tooth decay
□ Frequent sore throats
□ Grind teeth at night
□ Hoarse voice/frequent loss of voice

GASTROINTESTINAL

□ Belching
□ Flatulence/Gas
□ Black or Tarry Stools
□ Blood in Stool
□ Change in Stool
□ Colitis
□ Constipation
□ Diarrhea
□ Distention
□ Excessive Hunger
□ Heartburn
□ Food Intolerance
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Poor Appetite
□ Stomach Pain
□ Trouble Swallowing
□ Vomiting

HEMATOLOGIC

□ Anemia
□ Bruise easily

URINARY

□ Frequent urination
□ Blood in urine
□ Incontinence
□ Painful urination
□ Urinate more than once at night

NEUROLOGIC

□ Blackouts
□ Fainting
□ Numbness
□ Paralysis
□ Dizziness
□ Tremors
□ Seizures

PSYCHOLOGICAL

□ Anxiety
□ Depression
□ Insomnia/Hard to Fall Asleep
□ Nervousness
□ Poor Memory/Forget Quickly
□ Violent Thoughts
□ Suicidal Ideas
□ Tend to Worry

ENDOCRINE

□ Diabetes
□ Excessive Thirst or Hunger
□ Excessive Sweating
□ Lack of Sweating
□ Heat or Cold Intolerance
□ Thyroid Problem
□ Hair Loss
□ Dizzy when Rising Quickly
□ Excessive Weight Loss
□ Excessive Weight Gain

MUSCLES & JOINTS

□ Arthritis
□ Tendonitis
□ Bursitis
□ Gout
□ Trouble with/poor posture
□ Chronic pain
□ Pain with specific movement(s)
□ Pain relieved with anti-inflammatory drugs (aspirin, ibuprofen, Vioxx, etc…)
□ Pain, tenderness, or numbness in:
- Neck
- Shoulders
- Arms
- Elbows
- Wrist/hands
- Upper back
- Lower back
- Hips
- Knees
- Feet/ankles

**MALES ONLY: SEXUAL/HORMONAL

□ Prostate problems
□ Hernia
□ Erection trouble
□ Discharge
□ Premature ejaculation
□ Sexually transmitted disease
□ Testicular lump/pain
□ Itching/rashes
□ Vasectomy

**FEMALES ONLY:

□ Bleeding between Periods
□ Decreased Sexual Interest
□ Pain with Intercourse
□ Discharge
□ Itching
□ Sores
□ Yeast Infections
□ Sexually Transmitted Disease
□ PMS
- Breast Tenderness
- Cramping/Bloating
- Back Pain
- Over-Emotional
- Tired/Fatigue
- Other Pain
- Other Symptoms

□ Age at First Period_____
□ Number of Days in Cycle_____
□ Usual Length of Period_____
□ Start of Last Period Date_____
□ Number of Pregnancies_____
□ Number of Deliveries_____
□ Complications with Pregnancies _____
□ Birth Control Method_____

# DIET HISTORY

How much do you drink each day (8oz): Water:____ Juice: _____ Soda Diet: ____ Soda Regular: ____

Coffee: Regular: ____ Decaf: ____ Tea: Regular:____ Tea Sweet :____ Energy Drinks/Other:_____

List oils or fats that you use in cooking: _____

Do you frequently skip meals? Y N Are you on any special diet or nutrition program? Y N

Describe:

_____

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.

_____

What foods do you dislike? _____ What is/are your favorite food(s)?_____

Circle the foods you crave:

Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods Spicy foods Sour foods Cereals Dairy Other individual _____

*Do you use: (circle) butter margarine shortening coconut oil * Do you eat organic foods? Y N

*Do you know what partially hydrogenated fats are? Y N _____If yes, do you eat them? Y N

*Do you eat from fast food restaurants? Y N -- If yes, how often? _____

What do you usually eat for breakfast? _____

What do you usually eat for lunch? _____

What do you usually eat for dinner? _____

What do you usually eat for snacks (in between meals and/or before bed)? _____

What foods do you eat a lot of (at least once a day, every day)? _____

How many bowel movements do you have per day? _____

**A Bit More** ----

*Type of sport/activity/exercise routine you participate in:

*Hours you train/exercise average per week: _____ *Do you train by yourself or with others? (circle)

*Do you use a heart rate monitor? Y N *What type of shoes do you wear? (Name/Style)_____