CARDINAL CHIROPRACTIC CENTERS®

11509 Shelbyville Rd. Louisville, KY 40243 (502) 489 -8480
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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Occupation:		**Type of Work:**	
Previous or referring doctor:		**Date of last physical exam:**	
PERSONAL HISTORY:			
List any medical problems that other doctors have diagnosed, surgeries, or hospitalizations:			
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:			
List any traumas, accidents, injuries, or falls, including auto accidents. Provide date:			
List any broken bones you have ever had. Provide date:			

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Headaches	☐ Mid Back Pain	☐ Ringing in the ears
☐ Neck Pain	☐ Mid Back Stiffness	☐ Frequent Sinus Infections
☐ Neck Stiffness	☐ Low Back Pain	☐ Constipation/Poor Digestion
☐ Shoulder Pain/Stiffness	☐ Low Back Stiffness	☐ Frequent Urination
☐ Arm Pain	☐ Leg Pain	☐ Dizziness
☐ Arm Tingling/Numbness	☐ Leg Tingling/Numbness	☐ Asthma
☐ Wrist Pain/Weakness	☐ Ankle Pain/Weakness	☐ Cancer
☐ Hand Pain/Stiffness	☐ Foot Pain/Stiffness	☐ Diabetes
☐ Muscle Soreness	☐ Muscle Spasms	☐ Arthritis
☐ Joint Pain/ Stiffness	☐ Stroke	☐ Heart Disease
☐ WOMEN: Menstrual Problems	☐ MEN: Prostate Problems	☐ Sexual Dysfunction
☐ High Blood Pressure	Other pain/discomfort:	
Recent changes in:		
☐ Weight	☐ Energy level	☐ Ability to sleep

FAMILY HISTORY:			
Check any medical problems your family members have had, and please indicate who has had this problem:			
☐	Heart Problems – Who?	☐	Stroke – Who?
☐	Diabetes – Who?	☐	High Blood Pressure – Who?
☐	Cancer – Who?	☐	High Cholesterol – Who?
☐	Other (please describe):		

REASON(S) FOR BEGINNING CHIROPRACTIC CARE:

Chief Complaint:
When did the problem(s) begin?
How did the problem(s) begin?
Have you seen anyone else for this/these condition(s)? What treatment was provided? What were the results?
Have you had this/these problem(s) before?
What aggravates this/these condition(s)?
Are your symptoms getting worse?

YOUR HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ High	☐ Med	☐ Low		
	Rank fat intake	☐ High	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – packs/day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐	Yes	☐	No

X-RAY Confirmation:

This is to confirm that I have been advised by the doctor that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant and I consent to spinographic pictures.

Patient Signature: Date:

X-RAY Release:

I have requested the release of the x-rays of _____ which are part of Cardinal Chiropractic Centers' patient records. I hereby acknowledge receipt of the x-ray films. In consideration of the foregoing, I release and forever discharge the doctor from any and all responsibility and liability of any kind, nature, or character whatsoever arising from said release.

Patient Signature: Date:

Consent to Treatment of a Minor Child:

I hereby authorize the doctor to administer chiropractic care as deemed necessary to _____.
Relationship to child: _____

Parent or Guardian Signature: Date: