

BACK IN ACTION CHIROPRACTIC
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<http://www.back-n-action.com>

HEALTH INTAKE QUESTIONNAIRE

Dear Patient: Please complete this intake questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Please print clearly:

Name _____ Date _____
Address _____ Apt.# _____
City _____ State _____ Zip _____
Shipping Address (if different from Address above) _____

Home Phone(_____) _____ - _____ Work Phone(_____) _____ - _____
Fax(_____) _____ - _____

Email address _____

REFERRED BY: _____

Occupation _____ Employer _____
Date of Birth _____ Age _____ Sex: M/F Height _____ Weight _____

FAMILY HISTORY

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of child	Age	Sex	Any physical conditions/concerns?
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

Any household pets or other animals you or family members are in close contact with?

GENERAL HEALTH

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Please check the blocks below that apply.

MAJOR COMPLAINTS

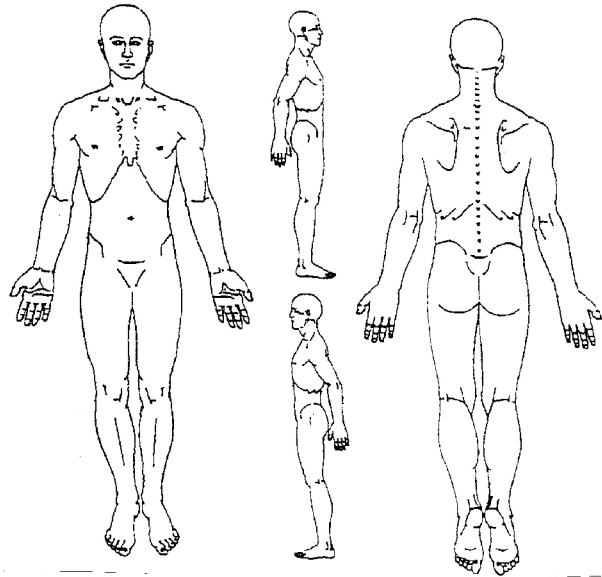
1. What are your major complaints?

2. Currently your pain is aggravated by

None	Pain		Numbness		Tingling			
Head							Coughing	
Neck							Sneezing	
Upper Back							Straining At Stool	
Mid Back							Neck Movement	
Lower Back							Reaching	
	R	L	R	L	R	L	Lifting	
Shoulder							Bending	
Arm							Sitting	
Forearm							Standing	
Hand							Walking	
Buttock							Other	
Hip							3. Since your symptoms began, have you noticed a change in	
Thigh							Bowel Function	
Leg							Ability to Maintain An Erection	
Foot							Bladder Function	

Please annotate on the diagram the following should they apply in regards to the type of pain you are currently experiencing.

Numbness - - - - -
 Pins & Needles OOOOOO
 Burning XXXXXX
 Stabbing //////////////
 Aching aaaaaa



4. REVIEW OF SYMPTOMS

4A. GENERAL

4B. SKIN

Normal		Normal	
Fatigue		Rash	
Weakness		Redness	
Fever		Itching	
Chills		Eczema	
Weight Change		Hair Changes	
Night Sweats		Nail Changes	
Other		Other	

4C. NEUROLOGICAL

Normal	
Headache	
Dizziness	
Fainting	
Convulsions	
Other	

4D. MOUTH/THROAT

Normal	
Sores	
Bleeding	
Absence of Taste	
Abnormal Taste	
Other	

4F. NOSE

Normal	
Pain	
Bleeding	
Absence of Smell	
Other	

4H.. GLANDULAR

Normal	
Heat/Cold Intolerance	
Sugar In Urine	
Goiter	
Tremor	
Other	

4J. REPRODUCTIVE/URINATION

Normal	
Inability to Hold Urine	
Painful Urination	
Frequent Urination	
Irregular Menstration	
Painful Menstration	
Abnormal Vaginal Bleeding	
Impotence	
Sterility	
Other	

4K. MENTAL

Normal	
Anxiety	
Depression	
Memory Loss or Impairment	
Phobias	
Mood Swings	
Other	

5. MEDICAL HISTORY

Have you been to a chiropractor?	
Do you have a family physician?	
(Women) To the best of your knowledge, are you pregnant?	
(Women) Are you under care of an OB/GYN?	
Have you been hospitalized in the past 5 years?	
Are you currently taking any medication?	
Any accidents or injuries in the past 5 years?	

4E. EARS

	R	L
Normal		
Hearing Trouble		
Ringing		
Pain		
Discharge		
Other		

4G. BREASTS

	R	L
Normal		
Lumps In Breast		
Pain		
Redness		
Pain		
Dimpling		
Discharge		
Other		

4I. EYES

	R	L
Normal		
Vision Trouble		
Pain		
Discharge		
Other		

4L. HEART/LUNGS

Normal	
Cough	
Wheezing	
Difficulty Breathing	
Swollen Extremities	
Blue Extremities	
Murmur	
Chest Pain	
Palpitations	
Other	

4M. STOMACH/INTESTINES

Normal	
Decreased Appetite	
Increased Appetite	
Abnormal Pain	
Vomiting	
Diarrhea	
Constipation	
Other	

Please check the blocks below that apply

5B. Which of the following Illnesses have you had?

No Previous Conditions/Illnesses		Ulcer	
Arthritis		Cancer	
Asthma		Polio	
Sinus Trouble		Rheumatic Fever	
Hay Fever		Serious Injury	
Allergies		Bone Fracture	
Tuberculosis		Dislocated Joints	
Diabetes		Spinal Disc Disease	
Epilepsy		Multiple Sclerosis	
Thyroid Trouble		Scoliosis	
High Blood Pressure		Mental/Emotional Difficulty	
Low Blood Pressure		Prostate Trouble	
Heart Trouble		Kidney Trouble	
HIV/ARC		Other	
AIDS			
Sexually Transmitted Disease			

5C. FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children
Cancer					
Diabetes					
Heart Trouble					
High Blood Pressure					
Stroke					
Multiple Sclerosis					
Headaches					
Neck Problems					
Back Problems					
Disc Problems					
Joint Problems					
Arthritis					
Pinched Nerve					
Osteoporosis					
Scoliosis					
Bad Posture					

5D. MEDICATIONS

Please circle any medications you are currently taking below that apply.

Anti-Inflammatory (Aspirin, Motrin) Muscle Relaxants Tranquilizers Pain Medications Birth Control Other

Nutritional supplements you are taking for this condition:

Do you smoke, drink coffee, alcohol, or soda? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____ Soda _____

What can we do to make you happier?

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any professional fees rendered to me will be immediately due and payable.

Patient's Signature _____ **Date** _____
Guardian/Spouse's Signature _____ **Date** _____