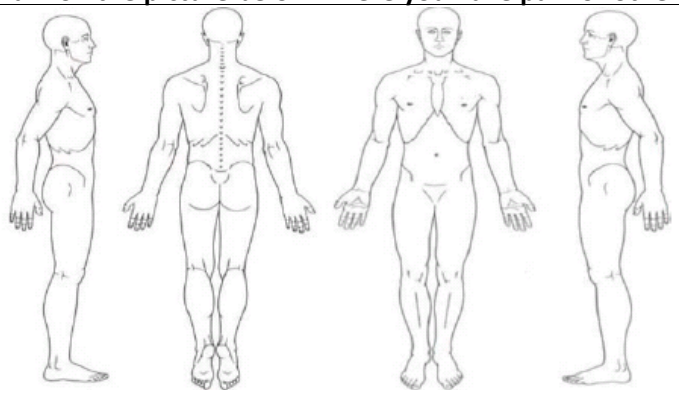
Mankato Chiropractic Center Patient Health Questionnaire

Name:_____ **Date:**_____

Describe your symptoms in detail:_____
_____
_____

When did these symptoms start?_____
What caused your symptoms to begin?_____

Mark on the picture below where you have pain or other symptoms



How often do you experience symptoms?

☐ Constantly (100-76% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (1-25% of the day)
☐ Sporadically (symptoms are not daily)

How are your symptoms progressing?

☐ Getting Better
☐ Not Changing
☐ Worsening

What best describes the nature of your pain?

☐ Sharp	☐ Burning	☐ Achy
☐ Stabbing	☐ Tingling	☐ Stiffness
☐ Shooting	☐ Spasming	☐ Tightness
☐ Dull pain	☐ Throbbing	☐ Pinching

Grade your pain level TODAY: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Have you been treated for this episode? Yes ☐ No ☐ When?_____

If yes, by whom? ☐ MD ☐ Chiropractor ☐ Massage Therapist ☐ PT ☐ Other_____

What treatment did you receive? _____

Occupation: _____ Full time ☐ Part time ☐

Physical activity at work:

☐ Sitting more than 50% of the day ☐ Light manual labor ☐ Manual labor ☐ Heavy labor ☐ Repeated motion

Patient Signature_____ Date:_____

See other side for more patient health information ➡

Mankato Chiropractic Center Patient Health Questionnaire Page 2

Name:_____ **Date:**_____

CHECK ONE:

- ☐ Current every day smoker
- ☐ Current occasional smoker
- ☐ Former smoker
- ☐ Never a smoker

Please Indicate:

Past	Present	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Lower Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/ Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	TMJ/ Jaw Pain
☐	☐	Hip/ Upper Leg Pain
☐	☐	Knee Pain
☐	☐	Ankle/ Foot Pain
☐	☐	Fibromyalgia
☐	☐	Joint Swelling
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Restless Leg Syndrome
☐	☐	Chest Pain
☐	☐	High Blood Pressure
☐	☐	Difficulty Breathing
☐	☐	Dizziness
☐	☐	Loss of Conciousness
☐	☐	Racing Heart
☐	☐	General Fatigue
☐	☐	Loss of Coordination
☐	☐	Rapid Weight Change
☐	☐	Bruise Easily
☐	☐	Anemia
☐	☐	Depression
☐	☐	Night Sweats
☐	☐	Insomnia
☐	☐	Alcohol Dependancy
☐	☐	Drug Dependence
☐	☐	Kidney Dysfunction
☐	☐	Kidney Stones
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Heartburn
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Nausea/ Vommiting
☐	☐	Difficulty Swallowing
☐	☐	Blood in Stool
☐	☐	Abdominal Pain
☐	☐	Loss of Appetite

Past	Present	
☐	☐	Cancer
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Lupus
☐	☐	Diabetes
☐	☐	HIV/ AIDS
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Osteoperosis
☐	☐	Multiple Sclerosis
☐	☐	Pregnancy
☐	☐	Pace Maker Implant
☐	☐	Car accident
☐	☐	Trauma

Immediate Family History of:

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Lupus
- ☐ Parkinsons
- ☐ Dementia

List all prescription medications and supplements you are currently taking (If you have a list the staff can make a copy)

_____

_____

_____

_____

List all allergies to medications:_____

List all surgical procedures you have had performed:_____

_____

_____