ADIO CHIROPRACTIC

-- Health History Questionnaire --

PERSONAL INFORMATION

Name:_____ Date:_____ Birth Date:_____

Address:_____ City:_____ Zip:_____

Phone:_____ Email:_____

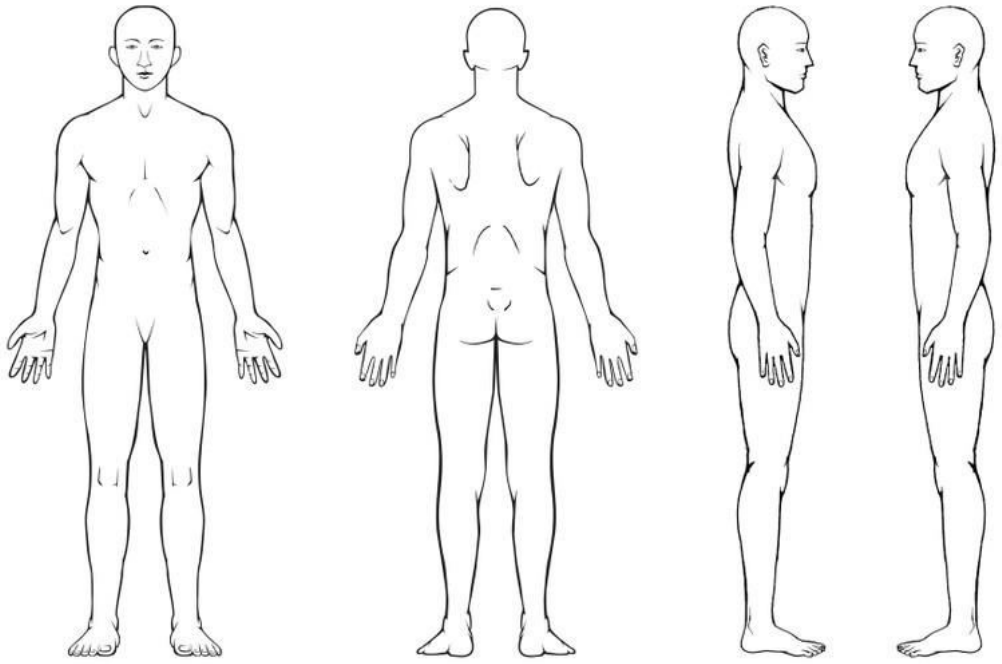
Occupation:_____ Years on job:_____

PLEASE INDICATE:

X = Pain

O = Numbness

Z = Tingling



QUALITY OF PAIN:

Dull/Achy ☐

Sharp/Stabby ☐

Burning ☐

Travels ☐

Please indicate on the scale the level of your pain experienced on average

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

Reason(s) for visit:_____

_____

How long has it been a problem?_____ It's getting : Worse ☐ Better ☐ Same ☐

Circle all that apply: Steady/Constant Comes and goes Morning Afternoon Night All Day

Was there an injury/incident that happened/triggered it?_____

What makes it better?_____ What makes it worse?_____

Any head aches (Please indicate any patterns):_____

Traumas or Surgeries (include dates):_____

Had chiropractic before?_____ Most recent X-ray or MRI?_____