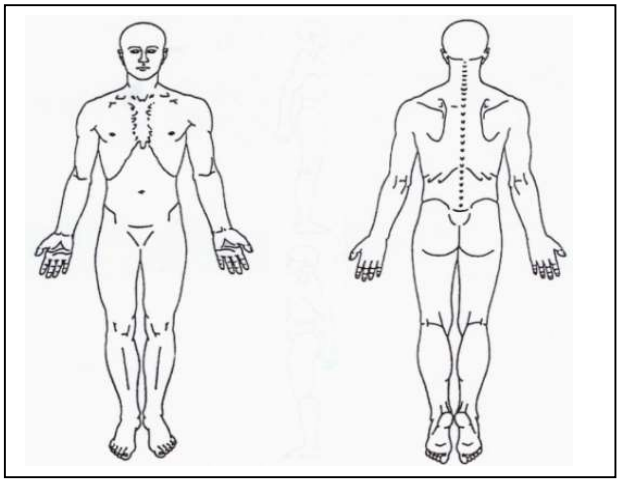
Creekside Chiropractic Center Health History Questionnaire

Please Print Name: _____

1. Please **mark** where you are or have been experiencing pain:



No Pain Very Painful

2. **Circle** your pain intensity: 0---1---2---3---4---5---6---7---8---9---10

3. When did your symptoms start?_____

4. How did they occur? _____

_____

5. How often do you experience your discomfort?_____

_____

6. How would you describe your pain? **Please circle**: Sharp / Stabbing /Burning / Numbness / Tingling / Throbbing /Aching

7. What makes your pain worse?

_____

_____

8. What makes your pain better? _____

_____

9. Have you ever had chiropractic care? ☐ Yes ☐ No Last date of care? _____

10. List all current medications, including over the counter and nutritional supplements you are taking:

_____

_____

11. Have you had a major illness or have had surgery? Please explain:_____

_____

12. Please check items below that pertain to your health **(Check Past or Present) and (Circle all that apply)**

PAST / PRESENT			PAST / PRESENT		
		Smoking/Tobacco Use			Auto Immune Disorders
		Exercise			Respiratory Lung Disorders: (Bronchitis/Asthma/COPD)
		Weight Gain/Loss			Liver Disorders: (Hepatitis/Cirrhosis)
		Fatigue			Urinary Tract Disorders: (Kidney Stones / Chronic Urinary Tract Infection)
		Sleep Difficulties			Reproductive System Disorders
		Arthritis			(Gastrointestinal Disorders: Ulcer / Constipation / Diarrhea / IBS)
		Headache			Endocrine Disorders: (Thyroid / Diabetes / Other)
		Cancer			Please explain below:
		Allergies/Sinus			
		High Blood Pressure			
		Heart Disease			Other disorders not listed:
		High Cholesterol			
		HIV			

Patient Signature: _____ Date: _____

9/7/16 KED