Zindt Chiropractic Center
3819 S M St
Tacoma, WA 98418

Health Questionnaire

Patient Information

Name_____ Date_____ Date of Birth_____
Last First Middle Initial

Patient Condition

Main Problem

Main reason for visit:_____

Is this condition due to an accident? YES / NO ☐ Auto ☐ Work ☐ Home ☐ Other:_____ Date:_____

Have you ever experienced this condition before? YES / NO If yes when?_____

What caused this condition?_____

When did your symptoms appear?_____ Is this condition getting worse? YES / NO

When you have the pain/symptoms how long does it last? (hours, days, etc.)_____

How often does the pain occur? Daily / Weekly / Monthly Do you have the pain: Occasionally / Frequently / Constantly

Does it interfere with your: ☐ Work ☐Sleep ☐ Daily Routine ☐ Recreation ☐ Other:_____

How bad is the pain? Mild / Moderate / Severe / Intolerable

Circle your pain on the 0 to 10 scale: (at rest) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

(with activity) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Circle the word (s) that best describe the pain: Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening like, Throbbing, Nagging, Burning, Deep, Stinging, Pressure like, Tingling

Does the pain travel to any other areas?_____

Activities or movements that are difficult/painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

What makes the condition better?_____

What makes the condition worse?_____

What treatments have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None ☐ Other:_____

Name of other doctor(s) who have treated you for this condition: _____

_____

Comments:_____

_____

_____

_____

_____

_____

_____

_____ **Patient Initials**

Other Problem ☐ **NOT APPLICABLE (only complete if you have an additional complaint)**

What other pain do you have?_____

Is this condition due to an accident? YES / NO ☐ Auto ☐ Work ☐ Home ☐ Other:_____ Date:_____

Have you ever experienced this condition before?_____ If yes when?_____

What caused this condition?_____

When did your symptoms appear?_____ Is this condition getting worse? YES / NO

When you have the pain/symptoms how long does it last? (hours, days, etc.)_____

How often does the pain occur? Daily / Weekly / Monthly Do you have the pain: Occasionally / Frequently / Constantly

Does it interfere with your: ☐ Work ☐Sleep ☐ Daily Routine ☐ Recreation ☐ Other:_____

How bad is the pain? Mild / Moderate / Severe / Intolerable

Circle your pain on the 0 to 10 scale: (at rest) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

(with activity) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

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Does the pain travel to any other areas?_____

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What makes the condition better?_____

What makes the condition worse?_____

What treatments have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None ☐ Other:_____

Name of other doctor(s) who have treated you for this condition: _____

Comments:_____

_____

Medications

☐Blood Pressure	☐Diabetic Meds.	Please list all medications that you are currently taking and major allergies:
☐Birth Control	☐Steroids	☐_____
☐Muscle Relaxant	☐Antibiotics	☐_____
☐Antidepressant	☐Anti-anxiety	☐_____
☐Pain Medication	☐Heart Meds.	☐_____
☐Cholesterol Meds.	☐Thyroid Meds.	☐_____
		☐_____

Family History

Relation	Living	Deceased	Age (now or at death)	Serious Illness/Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

_____Patient Initials

Personal Health History

Are you currently under the care of a Healthcare Provider or any other Doctor? YES / NO

If yes, for what condition(s)_____

_____

Provider's Name_____ Phone_____

Name of previous Chiropractor_____

Date of Last: Chiropractic Exam_____ Spinal X-ray_____ EMG _____

Cortisone Epidural_____ CT-Scan_____ MRI_____

Place an "X" to indicate if you have had any of the following:

☐ Headaches	☐ Irritable Bowel Syndrome	☐ Difficulty Walking
☐ Sinus Problems	☐ Liver Trouble/Hepatitis	☐ Skin Problems
☐ Dizziness	☐ Kidney Problems	☐ Easy Bruising
☐ Neck Pain	☐ Difficulty Urinating	☐ Anxiety
☐ Thyroid Problems	☐ Prostate Problems	☐ Depression
☐ Shoulder/Arm Pain	☐ Menstrual Problems	☐ Unexplained Fatigue
☐ Ear Problems	☐ Pelvic Pain	☐ Jaw Problems
☐ Asthma	☐ Heart Problems	☐ Arthritis, type:_____
☐ Throat Problems	☐ Poor Circulation	☐ Chronic Cough/Cold
☐ Difficulty Breathing	☐ Stomach Trouble	☐ Osteoporosis
☐ Mid Back/Rib Pain	☐ Colon Trouble	☐ Diabetes Type I or II
☐ Chest Pain	☐ Diverticulitis	☐ Hypertension/High Blood Pressure
☐ Wrist/Elbow/Hand Pain	☐ Stroke	☐ Cancer, type:_____
☐ Low Back Pain	☐ Knee Pain	☐ Glasses/Contacts
☐ Scoliosis	☐ Ankle/Foot Pain	☐ Frequent Infections
☐ Hip/Leg Problems	☐ Sciatica	

Other condition, please specify:_____

_____

Are you pregnant? YES / NO Due Date_____

Injuries / Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Infections	_____	_____

Have you ever:

Lost Consciousness	_____	_____
Had Mental/Emotional Disorders	_____	_____
Been Treated for a Spine/Nerve Disorder	_____	_____

_____Patient Initials

Social History

Work Activity: While at work I am usually: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Typing

My work consists of: ☐ Light Labor ☐ Heavy Labor ☐ Repetitive movements

What job did you do during most of your life?_____

Diet/Nutrition: Are you on any special diet? YES / NO If yes, for what reason?_____

Have you gained or lost over 10 pounds in the past 6 months without wanting to? YES / NO

How many caffeine drinks do you drink a day? (soda, coffee, tea, energy drinks) _____

Habits: Tobacco Use: Now? YES / NO Amount/Weekly_____ How Long?_____Years/Months

In the Past? YES / NO Amount/Weekly_____ How Long?_____Years/Months

Smoking / Chewing Tobacco

Alcohol Use: Now? YES / NO Amount/Weekly_____ How Long?_____Years/Months

In the Past? YES / NO Amount/Weekly_____ How Long?_____Years/Months

Do you have any concerns regarding domestic or sexual abuse? YES / NO

Functional Assessment

Please indicate your ability to perform the following activities:

Bending:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Carrying Groceries:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Dressing self:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Driving:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Extended computer use:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Household Chores:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Lifting:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Reading/Concentration:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Self Care:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Sitting:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Sleeping:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Walking:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Yard Work:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Recreation (golf, bowling):	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable

Describe any current activity limitations:_____

_____

Do you have any additional concerns at this time?_____

_____

_____

_____

_____

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my chiropractic evaluation at Zindt Chiropractic Center at this time.

Patient's Signature _____ Date_____

Signature of Parent/Guardian_____ Relationship_____

_____Patient Initials

_____Patient Initials