

OUTTEN CHIROPRACTIC

401 High House Rd., Suite 110
Cary, NC 27513

Date: _____

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete this form as accurately as possible. Your answers will help us to determine whether chiropractic can help you. If you do not sincerely believe your condition can respond satisfactorily, we will not accept your case. Thank you for your cooperation.

PERSONAL INFORMATION:

Full Name: _____ Age: _____ Birthday: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone # (Home): _____ (Work): _____ Social Security #: _____
____ Male ____ Female (Marital Status) M S W D Spouse's Name: _____
of Children: _____ Name(s): _____
E-Mail Address: _____
Occupation: _____ Employer: _____ Referred By: _____
By what name would you like to be addressed in our office: _____
Do you have Group Insurance? ____ Yes ____ No Company: _____
Person responsible for payment or bill: _____

MEDICAL INFORMATION:

Primary Care Physician: _____ Address: _____
Date of Last: Physical Exam: _____ Blood Pressure Check: _____ X-rays: _____
Medication(s) taken at present time: _____
List surgical operations & dates: _____
Is there any illness in your family? ____ YES ____ NO *If yes, give relation and illness:* _____
How would you grade your general stress level? ____ No Stress ____ Minimal Stress ____ Moderate ____ Greatly Stressed
Physical activity at work: ____ Sedentary more than 50% of workday ____ Light Manual ____ Manual Labor ____ Heavy Manual
General Physical Activity: ____ No regular exercise program ____ Light exercise program ____ Strenuous exercise program

CURRENT COMPLAINTS:

Purpose of this appointment? _____
Present Complaint: _____
When did your problem begin? (*Specific date if possible*) _____
Describe how your problem began: _____
Please describe the character of your current pain (*You may check one or more*):
____ Stabbing ____ Sharp/Dull ____ Aches/Sore ____ Throbbing ____ Numbness ____ Burning ____ Tingling ____ Other: _____
Is the pain: ____ Constant (76-100%) ____ Frequent (51-75%) ____ Occasional (26-50%) ____ Intermittent (25% or less)
How bad is your pain or ache? Please circle a number: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)
What makes it better? ____ Nothing ____ Lying Down ____ Walking ____ Standing ____ Exercise ____ Inactivity ____ Other: _____
What makes it worse? ____ Nothing ____ Lying Down ____ Walking ____ Standing ____ Exercise ____ Inactivity ____ Other: _____
Other doctors consulted for this condition?: _____
Treatment given: ____ Surgery ____ Spinal Injections ____ PT ____ A Back Support ____ Medication: _____
____ Spinal Adjustment ____ Other: _____ If none check here: _____
Have you had similar complaints in the past?: ____ Yes ____ No *If yes type of treatment received:* _____
Any prior auto, work or other accident? Give dates and details: _____

(Continue on back)

Are your complaints affecting your ability to work or otherwise be active?

No effect

Need limited assistance with common everyday tasks

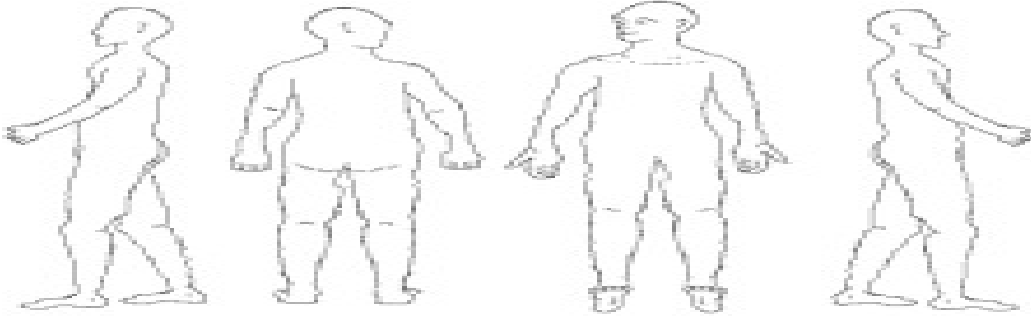
Have a significant inability to function w/o assistant

Some physical restrictions (able to perform light duty tasks)

Need assistance often

I am totally disabled (impaired)

SYMPTOM LOCALIZATION:



SIGNIFICANT PROBLEMS:

GENERAL

ALLERGY

DIZZINESS

EAR PROBLEMS

FATIGUE

FREQUENT COLDS

HEADACHES

NOSE BLEED

NUMBNESS

SINUS INFECTION

SORE THROAT

SUDDEN WEIGHT LOSS OR GAIN

TONSILLITIS

GASTROINTESTINAL

CONSTIPATION

DIARRHEA

GALL BLADDER TROUBLE

INTESTINAL TROUBLE

NAUSEA & VOMITING

STOMACH PROBLEMS

RESPIRATORY

CHEST PAIN

CHRONIC COUGH

DIFFICULT BREATHING

HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS

ALCOHOLISM

ANEMIA

ARTHRITIS

CANCER

DIABETES

HEART DISEASE

MENTAL DISORDERS

NERVOUS BREAKDOWN

POLIO

RHEUMATIC FEVER

GENITO-URINARY

FREQUENT URINATION

INABILITY TO CONTROL URINE

KIDNEY INFECTION OR STONES

PAINFUL URINATION

PROSTATE TROUBLE

MUSCLE & JOINT

ANKLE PAIN

ARM PAIN

ELBOW PAIN

FOOT TROUBLE OR PAIN

KNEE PAIN

LEG PAIN

NECK PAIN

PAIN BETWEEN SHOULDERS

PAINFUL LOW BACK

RIB PAIN

SWOLLEN JOINTS

FOR WOMEN ONLY

HOT FLASHES

IRREGULAR CYCLE

LUMPS IN BREAST

PAINFUL MENSTRUATION

HABITS

COFFEE

TEA

TOBACCO

ALCOHOL

EXCESSIVE SLEEP (OVER 8 HRS)

CARDIO-VASCULAR

HIGH BLOOD PRESSURE

HEART CONDITION

SWELLING OF ANKLES

To the best of my knowledge the preceding answers to the questions on this form are the complete truth regarding my health history.

Print Name: _____ Sign: _____ Date: _____

Patient or Guardian