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):_____ (Cell):_____

Social Security #:_____ E-Mail Address: _____

___ Male ___ Female (Marital Status) M S W D Spouse's Name: _____

# of Children: _____ Name(s): _____

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: _____

Have you taken any antibiotics over the past 6 months?_____

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%) ___Intermittent (26-50%) ___Occasional (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

___ Some physical restrictions (able to perform light duty tasks)

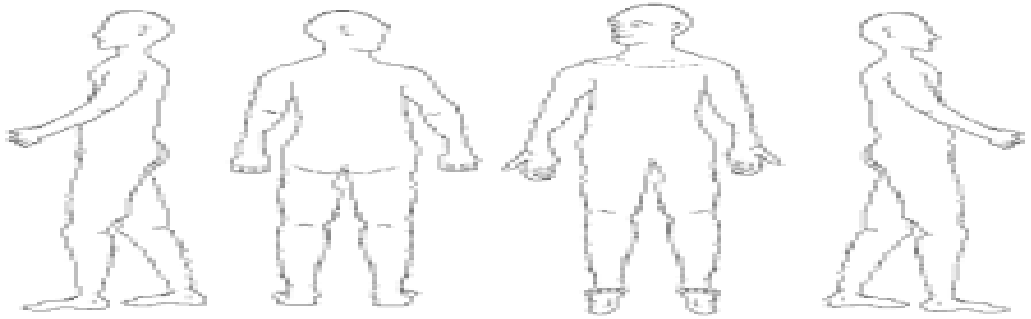
___ Need limited assistance with common everyday tasks

___ Need assistance often

___ Have a significant inability to function w/o assistant

___ I am totally disabled (impaired)

SYMPTOM LOCALIZATION:



Check where you are experiencing pain

SIGNIFICANT PROBLEMS:

GENERAL

___ ALLERGY

___ DIZZINESS

___ EAR PROBLEMS

___ FATIGUE

___ FREQUENT COLDS

___NOSE BLEED

___ NUMBNESS

___ SINUS INFECTION

___ SORE THROAT

___ SUDDEN WEIGHT LOSS OR GAIN

___ TONSILLITIS

❑ **HEADACHES**

If yes:

___DIZZINESS

GASTROINTESTINAL

___ CONSTIPATION

___ DIARRHEA

___ GALL BLADDER TROUBLE

___ INTESTINAL TROUBLE

___ NAUSEA & VOMITING

___ STOMACH PROBLEMS

RESPIRATORY

___ CHEST PAIN

___ CHRONIC COUGH

___ DIFFICULT BREATHING

MUSCLE & JOINT

___ANKLE PAIN

___ARM PAIN

CARDIO-VASCULAR

___HIGH BLOOD PRESSURE

___ HEART CONDITION

___ SWELLING OF ANKLES

HAVE YOU HAD ANY OF THE FOLLOWING?

___ AIDS

___ ALCOHOLISM

___ ANEMIA

___ ARTHRITIS

___ CANCER

___ DIABETES

___HEART DISEASE

___MENTAL DISORDERS

___NERVOUS BREAKDOWN

___DOUBLE VISION

___DIFFICULTY SWALLOWING

___DIFFICULTY SPEAKING

___BLACK OUTS

___NAUSEA

___NUMBNESS

___SUDDEN ONSET OF PAIN

___BALANCE & WALKING DIFFICULTY

GENITO-URINARY

___ FREQUENT URINATION

___ INABILITY TO CONTROL URINE

___ KIDNEY INFECTION OR STONES

___ PAINFUL URINATION

___ PROSTATE TROUBLE

___ELBOW PAIN

___FOOT TROUBLE OR PAIN

___KNEE PAIN

___LEG PAIN

___NECK PAIN

___PAIN BETWEEN SHOULDERS

___PAINFUL LOW BACK

___RIB PAIN

___SWOLLEN JOINTS

___WRIST PAIN

___HIP PAIN

___OTHER:_____

_____

_____

_____

___POLIO

___RHEUMATIC FEVER

HABITS

___COFFEE

___TEA

___TOBACCO

___ALCOHOL

___EXCESSIVE SLEEP (OVER 8 HRS)

FOR WOMEN ONLY

___HOT FLASHES

___IRREGULAR CYCLE

___LUMPS IN BREAST

___PAINFUL MENSTRATION

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

Patient or Guardian:

Print Name:_____ Sign:_____ Date:_____

Updated: August 28, 2017