CHICAGO NEUROSCIENCE INSTITUTE

# Health Questionnaire

Date: ______________ Patient Name: ____________________________________ Birthdate: _______________ SS#:___________

Primary reason for visit:______________________________________________________________________

Have you been treated for this problem before: ☐ No ☐ Yes If yes, by ☐ Medical physician ☐ Chiropractic physician

When did your symptoms first appear? ____________________ Is this condition getting worse? ☐ No ☐ Yes ☐ Unknown

Is it ☐ constant or ☐ does it come and go? Does it interfere with your ☐ Work ☐ Sleep ☐ Activities of daily living ☐ Recreation

Movements which are painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Driving a car

Your occupation:______________________________________________________________________
(Describe your work activities - sitting, lifting, driving, desk work, etc.)

Are you currently working ☐ Yes ☐ No. If no please indicate your first day of disability _______________________

Do you take ☐ Muscle relaxers ☐ Pain killers ☐ Insulin ☐ Birth control pills ☐ Over the counter meds.

Does coughing, straining, or sneezing bother you ☐ Yes ☐ No

| Please describe your | Sitting Tolerance | Standing Tolerance | Walking Tolerance |
|---|---|---|---|
| | ☐ None | ☐ None | ☐ None |
| | ☐ Less than 1 hour | ☐ Less than 1 hour | ☐ Less than 2 blocks |
| | ☐ Less than 3 hours | ☐ Less than 3 hours | ☐ More than 2 blocks |
| | ☐ More than 3 hours | ☐ More than 3 hours | |

List any surgeries you have had in the pas (Include Surgical Date)t:

Do you smoke? ☐ Yes ☐ No ___ # Pks./day ☐ <10yrs or ☐ > 10 yrs

Social drinking? ☐ None ☐ < 5 ☐ >10 PER / ☐ Day ☐ Week ☐ Month

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

| **Family history** | Age | Alive | Deceased | High blood pressure | Heart disease | Diabetes | Stroke | Neurologic Disease | Cancer | Overweight |
|---|---|---|---|---|---|---|---|---|---|---|
| Father | ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother | ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sibling | ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sibling | ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sibling | ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

List any prescription medications or vitamins you are currently taking with dosage:

Medications: Vitamins:

Any known allergies?

Date of last: Physical Exam: ____________ Spinal X-rays: ___________________ Blood/Urine tests: __________________

Neurologic Exam: ____________ Nerve Studies/EMG: ___________________ MRI, CT-scan, Bone scans: ________________

ECG/EKG: ____________ Angiogram: ___________________ Peripheral Vascular (Doppler) _______________

Where were studies performed: ______________________________________________________________________

**Conditions:** Check conditions you have or have had in the past.

| | | | |
|---|---|---|---|
| ☐ Autoimmune Disorder | ☐ Diarrhea | ☐ Hepatitis | ☐ Constipation |
| ☐ Alcoholism | ☐ Diabetes | ☐ Herniated disc | ☐ Kidney disease |
| ☐ Anemia | ☐ Digestive Disorders ( IBS, Crohn's UC ) | ☐ High cholesterol | ☐ Prostate problem |
| ☐ Appendicitis | ☐ Emphysema | ☐ HIV positive | ☐ Psychiatric care |
| ☐ Arthritis | ☐ Epilepsy | ☐ High Blood Pressure | ☐ Rheumatoid arthritis |
| ☐ Alcoholism | ☐ Emphysema | ☐ High Cholesterol Triglycerides | ☐ Rheumatic fever |
| ☐ Asthma | ☐ Food Allergies | ☐ Light Headedness/Dizziness | ☐ Scarlet fever |
| ☐ Bells palsy | ☐ Foot pronation | ☐ Liver disease | ☐ Spinal Stenosis |
| ☐ Bleeding/clotting disorders | ☐ Facial weakness | ☐ Leg Edema/swelling | ☐ Stroke |
| ☐ Breast lump | ☐ Fractures | ☐ Migraine headaches | ☐ Suicide attempt |
| ☐ Bronchitis | ☐ Gall Bladder Disease | ☐ Miscarriage | ☐ Stress or irritability |
| ☐ Cancer | ☐ Glaucoma | ☐ Mononucleosis | ☐ Sensitivity to sun and light |
| ☐ Carpal tunnel syndrome | ☐ Gout | ☐ Multiple sclerosis | ☐ Thyroid disease/problems |
| ☐ Cataracts | ☐ Heart disease | ☐ Measles | ☐ Tonsillitis |
| ☐ Chemical dependency | ☐ Heart murmur | ☐ Osteoporosis | ☐ Tuberculosis |
| ☐ Chicken pox | ☐ Heart arrhythmia | ☐ Pacemaker | ☐ Ulcers |
| ☐ Depression | ☐ Head injury/concussion | ☐ Polyneuropathy | ☐ Venereal disease |

## General Symptoms: Check symptoms you have or have had in the past year.

### GENERAL NEUROLOGIC
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Difficulty w/short term memory
- ☐ Difficulty w/long term memory
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Fragmented sleep
- ☐ Cognitive Impairment
- ☐ Nervousness
- ☐ Numbness or tingling
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain
- ☐ Hallucinations
- ☐ Difficulty w/word retrieval
- ☐ Muscle twitching
- ☐ Gait abnormalities

### GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Difficulty voiding

### CARDIOVASCULAR
- ☐ Calf cramping
- ☐ Chest discomfort/pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Exertional leg pain
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Shortness of breath

### EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Vision - flashes
- ☐ Vision - halos
- ☐ Intermittent loss of vision
- ☐ Hallucinations

### MEN Only
- ☐ Breast lump
- ☐ Impotence
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

### WOMEN Only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period: ____________________

Date of last pap smear: _________

Have you had a mammogram? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Number of children: ___________

## SPINE, FACE, AND EXTREMITY PRESENTATIONS: Check symptoms you have or have had in the past year.

### NECK (Cervical Spine)
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

### SHOULDERS

| SHOULDERS | Right | Left |
|---|---|---|
| ☐ Pain in shoulder joint | ☐ | ☐ |
| ☐ Pain across the shoulders | ☐ | ☐ |
| ☐ Can't raise arm | ☐ | ☐ |
| ☐ Above shoulder level | ☐ | ☐ |
| ☐ Overhead | ☐ | ☐ |
| ☐ Tension in shoulders | ☐ | ☐ |
| ☐ Pinched nerve in shoulder | ☐ | ☐ |

### MID-BACK (Thoracic Spine)
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Muscle spasms in mid-back

### ARMS & HANDS

| ARMS & HANDS | Right | Left |
|---|---|---|
| ☐ Pain in upper arm | ☐ | ☐ |
| ☐ Pain in elbow | ☐ | ☐ |
| ☐ Pain in forearm | ☐ | ☐ |
| ☐ Pain in hand | ☐ | ☐ |
| ☐ Pain in fingers | ☐ | ☐ |
| ☐ Pins & needles in arm | ☐ | ☐ |
| ☐ Pins & needles in fingers | ☐ | ☐ |
| ☐ Numbness in arm | ☐ | ☐ |
| ☐ Numbness in fingers | ☐ | ☐ |
| ☐ Weakness of arm | ☐ | ☐ |
| ☐ Weakness of hand | ☐ | ☐ |
| ☐ Hands cold | ☐ | ☐ |
| ☐ Muscle twitching | | |

### LOW BACK (Lumbar Spine)
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back
- ☐ Muscle spasms in low back

### HIPS, LEGS, & FEET

| HIPS, LEGS, & FEET | Right | Left |
|---|---|---|
| ☐ Numbness/Tingling | ☐ | ☐ |
| ☐ Pain in buttocks | ☐ | ☐ |
| ☐ Pain in hip joint | ☐ | ☐ |
| ☐ Pain down leg | ☐ | ☐ |
| ☐ Pain in knee | ☐ | ☐ |
| ☐ Pain in ankle | ☐ | ☐ |
| ☐ Pain in foot | ☐ | ☐ |
| ☐ Weakness of lower leg | ☐ | ☐ |
| ☐ Weakness of upper leg | ☐ | ☐ |
| ☐ Weakness of knee | ☐ | ☐ |
| ☐ Leg cramps | ☐ | ☐ |
| ☐ Muscle twitching | | |

### FACE

| FACE | Right | Left |
|---|---|---|
| ☐ Numbness | ☐ | ☐ |
| ☐ Weakness | ☐ | ☐ |
| ☐ Pain | ☐ | ☐ |
| ☐ Pins and needles | ☐ | ☐ |

## Please list other doctors you have seen in the past 5 years

1. ______________________________City/State: __________________________ Reason For Seeing: ________________________________
2. ______________________________City/State: __________________________ Reason For Seeing: ________________________________
3. ______________________________City/State: __________________________ Reason For Seeing: ________________________________
4. ______________________________City/State: __________________________ Reason For Seeing: ________________________________

Whom may we thank for referring you: ____________________________________________________________________________________________

I certify that the above information is correct to the best of my knowledge. This health history is accurate and thorough in order aid the physician to recommend the proper care that I might require. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____________________________________ Date: ______________________________