Dr. Amy Winchester, D.C.
(559) 250-5116
dr.amy.winchester@gmail.com

Health Questionnaire

Patient Information

First Name _____ **Last Name** _____ **M.I.** __

Address _____

_____

City _____ **State** _____ **Zip** _____

Mobile Phone □_____ **Secondary Phone** □ _____

Email □_____

Date of Birth _____/_____/_____ **Age** _____ **Gender** _____

Emergency Contact Name _____

Relationship _____ **Phone** _____

*Please check the box of preferred contact method.

How Did You Hear About Us?

- ▫ **Patient**
- ▫ **Dr. Amy**
- ▫ **Facebook**
- ▫ **Google**
- ▫ **Advertisement**
- ▫ **Another Chiropractor** _____
- ▫ **Referral from Doctor** _____
- ▫ **Other** _____

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Allergies

Are you allergic to any medications? □No □ Yes

If yes, which medications? _____

List any other allergies. _____

Smoking History

Do you currently use tobacco of any kind?

□ Never □ Former □ Smoker □ Smokeless □ Nasal

If yes, how often do you use tobacco? □ Every Day □ Sometimes

Are you interested in quitting? □ Yes □ No

Medications

Do you currently use any recreational drugs? □ Yes □ No

Medication Name	Quantity/Dosage	Frequency

Vitamins, Minerals, Herbs	Quantity/Dosage	Frequency

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Social History

Job Description: _____

What do you do most of your day at work? (i.e. sitting, standing, heavy labor, etc.)

_____

Are you on a special diet? □ Yes □ No Why? What is it? _____

Have you gained/lost over 10lbs in the past 6 months without meaning to?□Yes□No

How many 8oz glasses of water do you drink a day? _____

Alcohol use: □ No □ Occasional □ Socially □ 3x week □ Every day

Coffee consumed: □ No □ Occasional □ Socially □ 3x week □ Every day

Soda consumed: □ No □ Occasional □ Socially □ 3x week □ Every day

How many hours of sleep are you getting each night? _____

Do you feel well rested most days? □ Yes □ No

How many days per week do you exercise for 30 minutes or more? _____

What kind of exercise? (running, weights, Crossfit, etc.)_____

What is the intensity of your exercise on a scale of 1-10? _____

What are your major stressors? _____

What are your health goals? _____

What would you like to accomplish with your chiropractor? _____

Chiropractic History

Have you seen a chiropractor before? □ Yes □ No If so, who? _____

Date of last visit? _____ Type of treatment? _____

Were you satisfied with your care? □ Yes □ No Why? _____

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Personal Health History

Do you have a primary healthcare provider? □ Yes □ No

Any current conditions being treated? □ Yes □ No _____

Doctor's Name _____ Phone _____

Have you been diagnosed with hypertension recently? □ Yes □ No

Have you been diagnosed with diabetes recently? □ Yes □ No If so, Type I or II? ____

Are you compliant with your treatment? □ Yes □ No

Please use the boxes below to describe any imaging you have had.

Type (X-Ray, MRI, CT, mammogram, etc.)	Date	Results

Surgeries

Date	Procedure	Description	In or Out Patient?

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Immunizations: □ All Recommended Vaccines □ None

□ adenovirus	□ DTaP	□ haemophilus B
□ hepatitis B	□ influenza	□ IPV (polio)
□MMR	□ pneumococcal	□ rotavirus
□ tetanus	□ varivax (chicken pox)	□ other:

Childhood Illnesses:

□ ADD	□ atopic dermatitis	□ allergies/hayfever
□ anemia	□ asthma	□ bedwetting
□ cerebral palsy	□ chicken pox	□ crohn's/colitis
□ depression	□ diabetes	□ ear infections
□ fetal drug exposure	□ headaches	□ hepatitis
□ HIV	□ measles	□mumps
□ psoriasis	□ rash	□ scoliosis
□ seizures	□ sickle cell	□ spina bifida

□other: _____

Adult Illnesses:

□ ADD	□ Alzheimer's	□ arthritis
□ asthma	□ cancer	□ cerebral palsy
□ chicken pox	□ colitis	□ CRPS (RSD)
□ CVA (stroke)	□ cystic kidney disease	□ depression
□ diabetes	□ eczema	□ emphysema
□ eye problems	□ fibromyalgia	□ heart disease
□ hepatitis	□ HIV	□ high blood pressure
□ influenza	□ liver disease	□ lung disease
□ lupus erythema	□ multiple sclerosis	□ Parkinson Disease
□ unspecified pleural effusion	□ pneumonia	□ psoriasis
□ psychiatric condition	□ scoliosis	□ seizures
□shingles	□ STD's	□ other: _____

Injuries: (Please include dates and type, i.e. back injuries, broken bones, falls, fractures, head injuries, motor vehicle accidents, soft tissue injuries, joint injuries, major lacerations.) _____

_____

_____

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Review of Systems

Constitutional □ None	□ chills □ fever □ weight gain/loss	□ loss of appetite □ daytime drowsiness	□ fatigue □ night sweats
Eyes/Vision □ None	□ blindness □ double vision □ photophobia	□ blind spots □ eye problems □tearing	□ cataracts □ itching □ wears contacts/glasses
Ears, Nose, Throat □ None	□ dizziness □ fainting □ frequent sore throats □ nosebleeds □ sinus infection	□ ear discharge □ hearing loss □ history of head injury □ nasal congestion	□ ear pain □ headaches □ loss of sense of smell □ runny nose
Respiration □ None	□ asthma □ shortness of breath	□ cough □ sputum production	□ wheezing □ coughing up blood
Cardiovascular □ None	□ claudication □ high blood pressure □ varicose veins □ orthopnea (difficulty breathing lying down)	□ heart problem □ low blood pressure □ ulcers	□ heart murmur □ paroxysmal nocturnal dyspnea □ palpitations □ shortness of breath with exertion
Gastrointestinal □ None	□ abdominal pain □ black/tarry stool □ heartburn □ jaundice □ difficulty swallowing	□ abnormal stool □ constipation □ hemorrhoids □ ulcers	□ belching □ diarrhea □ indigestion □ rectal bleeding
Female □ None/Not Applicable	□ abnormal vaginal bleeding □ burning urination □ hormone therapy □ vaginal discharge	□ birth control □ irregular menstruation □ cramps Currently pregnant? □ Yes □ No	□ breast lump/pain □ frequent urination □ urine retention
Male □ None/Not Applicable	□ burning urination □ hesitancy/ dribbling	□ erectile dysfunction □ prostate problems	□ frequent urination □ urine retention

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Endocrine □ None	□ cold intolerance	□ diabetes	□ excessive appetite
	□ excessive hunger	□ excessive thirst	□ goiter
	□ hair loss	□ heat intolerance	□ voice changes
	□ unusual hair growth		
Skin □ None	□ change in nail texture	□ change in skin color	□ history of skin disorders
	□ hair loss	□ hives	□ itching
	□ numbness	□ rash	□ skin lesions/ulcers
	□ varicosities		
Nervous System □ None	□ dizziness	□ facial weakness	□ headache
	□ numbness	□ limb weakness	□ loss of consciousness
	□ loss of memory	□ seizures	□ sleep disturbance
	□ slurred speech	□ stress	□ stroke
	□ unsteadiness of balance		
Psychological □ None	□ anxiety	□ behavioral change	□ bi-polar disorder
	□ confusion	□ convulsions	□ depression
	□ insomnia	□ memory loss	□ mood change
	□ loss or change of appetite		
Hematologic □ None	□ anemia	□ bleeding	□ blood clotting
	□ blood transfusion	□ bruising easily	□ fatigue
	swollen lymph nodes		

□ **Please check here if you have had a vaccine in the last 10 days.**

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Family History of Illness

Relation		Serious illness/cause of death
Father	☐ No significant disease ☐Has/had:	
Paternal Grandfather	☐ No significant disease ☐Has/had:	
Paternal Grandmother	☐ No significant disease ☐Has/had:	
Mother	☐ No significant disease ☐Has/had:	
Maternal Grandfather	☐ No significant disease ☐Has/had:	
Maternal Grandmother	☐ No significant disease ☐Has/had:	
Brother (s)	☐ No significant disease ☐Has/had:	
Sister (s)	☐ No significant disease ☐Has/had:	
Son (s)	☐ No significant disease ☐Has/had:	
Daughter (s)	☐ No significant disease ☐Has/had:	

Please use the area below to describe any other health related concerns or questions before we address your current condition.

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Patient Condition

Reason(s) for visit: _____

Is this condition due to an accident: □ Yes □ No If yes, what type of accident? □ Auto

□ Work □ Home □ Other: _____

How were you injured? _____

When did your symptoms appear? _____

Is this condition worsening? _____ How often do you have this problem? _____

Is it constant? Or does it come and go? _____

Activities or movements that are difficult/painful to perform: □ Sitting □ Standing

□ Walking □ Bending □ Lying Down □ Working □ Driving □ Other: _____

Circle your pain level below on a scale of 0(no pain) to 10 (worst pain of your life)

Currently	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

What helps to alleviate the pain? □ None □ NSAIDs □ Ice □ Heat □ Stretching

□ Chiropractic □ Massage □ Rest □ Movement □ Other:_____

What treatment have you already received for your condition?

□ Medications □ Surgery □ None □ Physical Therapy □ Chiropractic Care

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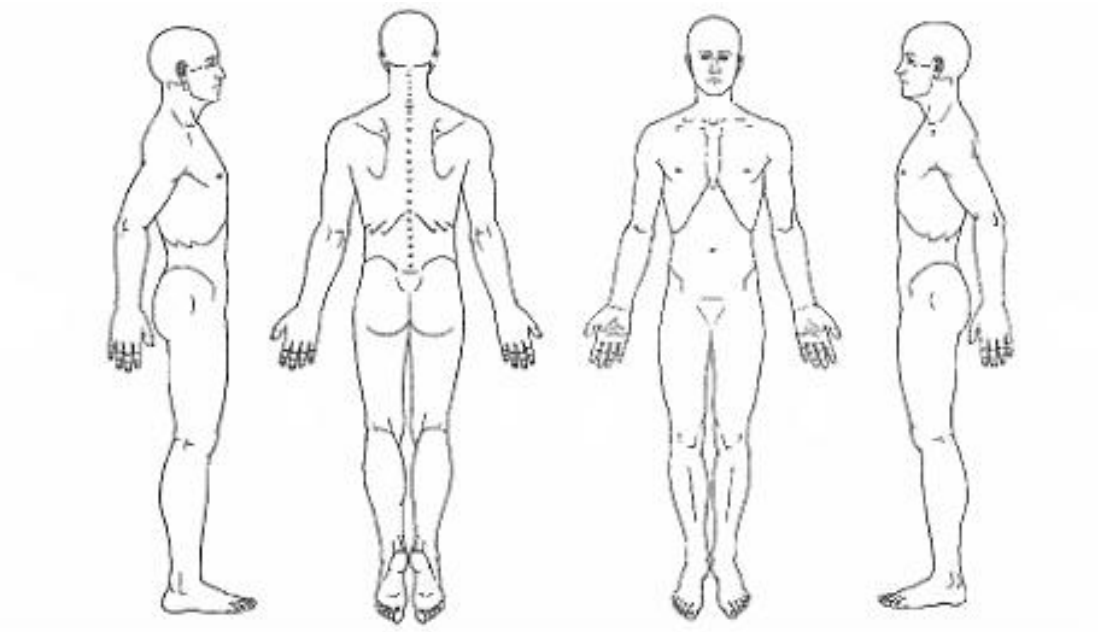
Please use the diagram below to mark your complaint(s).



Signature _____ Date _____

The signature above indicates that the answers I have given are correct to the best of my knowledge.

Office Use Only:

Height: Weight: Blood Pressure: