Core Chiropractic & Wellness
Health History Questionnaire

Did your symptoms developed from: Job Related Injury ☐ Auto Accident ☐ Other Accident ☐ Illness ☐ Unknown Cause ☐ Gradual Onset ☐ Date Occurred:________________________

Symptoms have persisted for # _____Hour(s) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

Please describe your present condition/symptoms:

Symptoms/Complaints: Come & Go ☐ Are Constant ☐ Both ☐

Symptoms: (check all that apply) Dull ☐ Achy ☐ Sharp ☐ Numb ☐ Tingling ☐ Throbbing ☐ Spasms ☐ Deep ☐ Weak ☐ Burning ☐ Shooting ☐ Stabbing ☐ Tense ☐ Other ☐ ____________________

Activities that Aggravate your Condition: (check all that apply): Bending ☐ Lifting ☐ Lying Down ☐ Standing ☐ Sitting ☐ Walking ☐ Reaching ☐ Coughing ☐ House Work ☐ Getting Up/Down ☐ Job Duties ☐ Yard Work ☐ Exercise ☐ Carrying Objects ☐ Other ☐ ________________________

Activities that Relieve your Condition: (check all that apply) Bending ☐ Lifting ☐ Lying down ☐ Reaching ☐ Sitting ☐ Standing ☐ Turning Head ☐ Walking ☐ Other?

Does pain wake you up at night? No ☐ Yes ☐ if so, how many hours of sleep do you get? ___________
Are your symptoms worse during certain times of the day? No ☐ Yes ☐ if so, When? _____________________

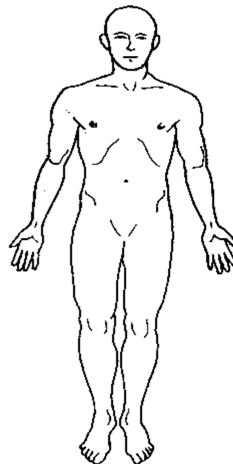
Additional Symptoms You May Be Experiencing or Have Had Within The Last Two Months: (check all that apply)

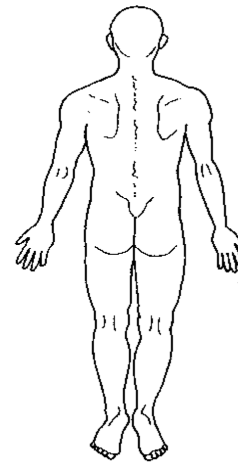
Condition	Y	N	Condition	Y	N	Condition	Y	N
Blurred Vision			Asthma			Heart Attack		
Headaches/Migraines			Bronchitis			High Blood Pressure		
Dizziness			Shortness of Breath			Stroke		
Depression			Emphysema - COPD			Seizures		
Anxiety			Pneumonia			Chest Pain - Angina		
Constipation			Sore Throat			Diabetes		
Diarrhea			Cough			Skin Problems		
Stomach Ulcers			Thyroid Problems			Kidney Disease		
Heart Burn			Leg Swelling/Edema			Cancer		
Abdominal Pain			Weight Gain/Loss			Fever/Night Sweats		
Muscle Weakness			Cold Feet/Hands			Stress		
Back or Neck Pain			Arthritis			Bowel/Bladder Issues		

Family History	Y	N		Y	N		Y	N
Cancer			High Blood Pressure			Diabetes		
Stroke			Heart Attack			Other?		
Social History	**Y**	**N**		**Y**	**N**		**Y**	**N**
Tobacco			Packs Per Day?					
Alcohol			How Often?					
Allergies			**List Current Medications/Vitamins**					
Female History	Are You Pregnant Y ☐ N ☐			Date of Last Menstrual Cycle?				

Past Medical History				
Have You Ever?	Y	N	When	Please Explain
Broken Bones				
Had Surgery				
Been in an Auto Accident				
Been Hospitalized				
Had Sprains/Strains				

Current Symptoms	
Please use the following letters to indicate the TYPE and LOCATION of your symptoms on the Diagram	
A=Ache	N=Numbness
B=Burning	S=Sharp
O=Other:	





Patient Signature:____ Date:____________________

Spouse’s or guardian’s signature ______________________Date_________________