Well Adjusted
Chiropractic and Acupuncture Clinic, p.c.

www.welladjustedonline.com

Health Questionnaire

Patient Name: _____ Age:_____ Sex: ___ Attending Doctor: _____ Date: _____

Please indicate the reason(s) of your visit today: _____

_____

_____

Are you under medical care for a specific condition? If so please list the condition and the care received: _____

_____

List all the medications you are currently taking (including birth control pill): _____

_____

_____

List the vitamins and supplements you are currently taking: _____

_____

What is your occupation? (Describe the physical demands of your daily activities): _____

_____

Have you had any trauma? (Motor vehicle accident, fall, sport injury…): _____

_____

_____

List the different doctors (and their specialty) you have seen in the past three years and indicate the reason for the visits:

Date Specialty Reason for visit

_____

_____

_____

List hospitalizations and/or surgeries you have had and indicate the reason:

Date Hospitalization/surgery Reason

_____

_____

_____

Do you have any concern about your health that you would like to discuss? □ Yes □ No

_____

_____

_____

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409 E. Third Street
Cameron, Mo 64429
Ph: 816-632-4405
Fax: 816-632-4406
www.welladjustedonline.com

Health Questionnaire

Patient Name: _____ Age:_____ Sex: ___ Attending Doctor: _____ Date: _____
Check the health problems you currently have or have had previously:

Head/ears/eyes/nose/throat:
1. □ Allergies
2. □ Frequent cold, sore throat, hoarseness, tonsillitis
3. □ Headaches
4. □ Sinusitis
5. □ Nose bleeds
6. □ Ear infection or discharge
7. □ Hearing problems, ringing in the ears
8. □ Eyestrain, vision Impairment
9. □ Dental problems
10. □ Jaw problems

Cardiovascular:
11. □ Heart problems
12. □ Rapid, slow or irregular heart beat
13. □ High or low blood pressure
14. □ Stroke
15. □ Shortness of breath
16. □ Aneurysm

Respiratory:
17. □ Persistent cough
18. □ Difficulty breathing or asthma
19. □ Pneumonia

Digestive:
20. □ Excessive hunger or poor appetite
21. □ Indigestion or nausea after eating
22. □ Heartburn
23. □ Stomach pain
24. □ Liver or Gall bladder problem
25. □ Unexplained weight gain or loss
26. □ Intestinal problems (constipation, diarrhea, colitis, gas, IBS)

Urinary tract:
27. □ Bed-wetting, incontinence
28. □ Blood in urine
29. □ Excessive, frequent, painful or difficult urination
30. □ Kidney problems

Male Reproductive System:
31. □ Pain in testicles
32. □ Sexual difficulties
33. □ Prostate problems

Female Reproductive System:
34. □ Breast problems (soreness, lump…)
35. □ Menstrual problems (pain, irregular or profuse flow, PMS)
36. □ Endometriosis
37. □ Sexual difficulties
38. □ Menopause problems
39. □ Miscarriage or abortion
□ # of successful pregnancies_____

General health information:
40. □ Anxiety, nervousness, depression
41. □ Memory loss, confusion
42. □ Fainting or seizures
43. □ Diabetes
44. □ Skin problems
45. □ Sweats
46. □ Thyroid problems
47. □ Cold hands and feet
48. □ Temperature control problems (always cold or hot)
49. □ Cancer or Tumor
50. □ Severe infection

Musculoskeletal:
51. □ Shoulder, Arm or Hand problems
52. □ Hip, Leg or Foot problems
53. □ Back problems (Neck, mid back or low back)
54. □ Painful or swollen joints – Arthritis
55. □ Fractures
56. □ Have you ever been in a motor vehicle accident?
57. □ Do you have pain interfering with your sleep, work, or activity

Lifestyle: (Check if you do any of the following)
58. □ Consume soft drinks
59. □ Consume caffeine
60. □ Use tobacco
61. □ Consume alcoholic beverages
62. □ Use recreational drugs
63. □ Exercise Regularly
64. □ Have recreational activities (tennis, golf…)
65. □ Wear arch supports or heel lift
66. □ What is your average number of hours of sleep per night ___

Family History: Does any member of your family have or ever had
67. □ Arthritis (type:_____)
68. □ Diabetes
69. □ Heart disease
70. □ Kidney disease
71. □ Cancer

_____
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