

CHIROPRACTIC SOLUTIONS *by dr julie*

2525 Nelson Miller Pkwy Suite #104 Phone: 502/253-1135 Dr. Julie L. Lyles
 Louisville, KY 40223 Fax: 502/253-1136

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
 and will become part of your medical record.

DATE:

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Occupation:		Type of Work:	
Medical Doctor:		Date of last physical exam:	
PERSONAL HISTORY:			
List any medical problems that other doctors have diagnosed, surgeries, or hospitalizations:			
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:			
List any traumas, fractures, accidents, injuries, or falls, including auto accidents. Provide date:			
List any sports that you played in the past or currently play:			
Check if you have/have had any symptoms in the following areas to a significant degree/briefly explain.			
<input type="checkbox"/> Headaches	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Ringing in the ears	
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Mid Back Stiffness	<input type="checkbox"/> Frequent Sinus Infections	
<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Constipation/Poor Digestion	
<input type="checkbox"/> Shoulder Pain/Stiffness	<input type="checkbox"/> Low Back Stiffness	<input type="checkbox"/> Frequent Urination	
<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Arm Tingling/Numbness	<input type="checkbox"/> Leg Tingling/Numbness	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Wrist Pain/Weakness	<input type="checkbox"/> Ankle Pain/Weakness	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Hand Pain/Stiffness	<input type="checkbox"/> Foot Pain/Stiffness	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Muscle Soreness	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> WOMEN: Menstrual Problems	<input type="checkbox"/> MEN: Prostate Problems	<input type="checkbox"/> Sexual Dysfunction	
Recent changes in:			
<input type="checkbox"/> Weight	<input type="checkbox"/> Mood	<input type="checkbox"/> Flexibility	
<input type="checkbox"/> Energy level	<input type="checkbox"/> Ability to sleep	<input type="checkbox"/> Other pain/discomfort:	

NAME _____ DATE _____

FAMILY HISTORY:

List any medical problems that your parents, grandparents , siblings, aunts/uncles, or children suffer from or take medication for:

--

TODAY'S COMPLAINT:

Why are you here?

Have you had this/these problems before? ? Yes No If so, When:

When did the problem(s) begin?

How did the problem(s) begin?

Have you seen anyone else for this/these condition(s)? What treatment was provided? What were the results?

What aggravates this/these condition(s)?

Are your symptoms getting worse?

What makes the condition better?

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)	<input type="checkbox"/> Mild exercise (climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional Vigorous Exercise (less than 4x/week for 30 minutes)	<input type="checkbox"/> Regular vigorous exercise (4x/week for 30 minutes)
Diet	Are you dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?	
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you concerned about the amount you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you drive after drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tobacco	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Cigarettes – pks./day: _____ Chew - #/day: _____ Other: _____	
	# of years: _____ Or year quit: _____	
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	