

Health Questionnaire
M^cCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

A. PATIENT INFORMATION

Patient Name: _____ **Date:** ____/____/____

Marital Status: **Sex:** **Patient Lives With:**
 Single M Alone Parents
 Married F Spouse Roommate(s)
 Separated **Children:** Children Assisted Living
 Divorced 0 1 2 3 Other: _____
 Widowed 4 5+

B. PATIENT'S COMPLAINTS

Examination with no complaints

1. Mark Your Present Complaints Below
Neck/Back

		Same as Left	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Neck	Left																									
	Right	<input type="checkbox"/>																								
Upper Back	Left																									
	Right	<input type="checkbox"/>																								
Mid Back	Left																									
	Right	<input type="checkbox"/>																								
Low Back	Left																									
	Right	<input type="checkbox"/>																								
Ribs	Left																									
	Right	<input type="checkbox"/>																								

When did your neck/back complaints begin?
Date: ____/____/____

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Upper / Lower Extremities

		Same as above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
L E F T	Shoulder																									
	Arm	<input type="checkbox"/>																								
	Elbow	<input type="checkbox"/>																								
	Forearm	<input type="checkbox"/>																								
	Wrist	<input type="checkbox"/>																								
	Hnds/Fingrs	<input type="checkbox"/>																								
R I G H T	Shoulder																									
	Arm	<input type="checkbox"/>																								
	Elbow	<input type="checkbox"/>																								
	Forearm	<input type="checkbox"/>																								
	Wrist	<input type="checkbox"/>																								
	Hnds/Fingrs	<input type="checkbox"/>																								
L E F T	Hip																									
	Buttock	<input type="checkbox"/>																								
	Thigh	<input type="checkbox"/>																								
	Knee	<input type="checkbox"/>																								
	Leg/Calf	<input type="checkbox"/>																								
	Ankle	<input type="checkbox"/>																								
	Foot	<input type="checkbox"/>																								
R I G H T	Hip																									
	Buttock	<input type="checkbox"/>																								
	Thigh	<input type="checkbox"/>																								
	Knee	<input type="checkbox"/>																								
	Leg/Calf	<input type="checkbox"/>																								
	Ankle	<input type="checkbox"/>																								
	Foot	<input type="checkbox"/>																								

When did your **upper** extremity complaint begin?
 Date: ___/___/____

When did your **lower** extremity complaint begin?
 Date: ___/___/____

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B. PATIENT'S COMPLAINTS (CONTINUED)

2. How Did Your Complaints Begin?

- Unknown Suddenly Gradually

3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?

- Unknown Work Accident/Injury Personal Injury
 Auto Accident Home Accident Sports Injury
 Other – Describe: _____
-
-

4. How Would You Rate Your Pain Today Where 0 Is No Pain And 10 Is The Worst Pain?

- No 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Pain Possible

5. When Are Your Symptoms Worse?

- Morning Afternoon Evening Night
 Always the Same

6. What Makes Your Condition Better?

- Nothing Stretching Heat Rest
 Sitting Exercise Ice Standing
 Medications Other: _____

7. What Makes Your Condition Worse?

- Nothing Coughing Reaching Standing
 Sneezing Lifting Sitting Pulling
 Bending Walking Straining Turning
 Other: _____

8. Have Any Of Your Complaint(s) Existed In The Past? Yes No

If Yes, Indicate below

- Neck Upr Back Mid Back Low Back Ribs
 Shoulder Arm Elbow Forearm Wrist
 Hnd/Fngrs Buttock Hip Thigh Knee Leg/Calf
 Ankle Foot Others: _____

9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office? Yes No If Yes, List Dates, Treatments And Doctors.

10. Since Your Symptoms Began, Have You Noticed A Change In?

- Bowel Function
 Bladder Function No To All
 Sexual Function

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C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.

- 1. Where Is The Pain Associated With Your Headaches Located?**
 Left Side Of Head Right Side Of Head Base Of Skull Left Jaw Joint
 Right Jaw Joint Over Eyes Behind Eyes Over Sinuses
- 2. On What Date Did Your Headaches Begin?**
Date: ___/___/____ Same As Neck/Back Complaints
- 3. How Does The Intensity Of Your Headaches Rate?**
No 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Pain Possible
- 4. What Describes Your Pain?**
 Dull Sharp Aching Stabbing Deep Vice-like Burning
 Throbbing/Pulsating Other: _____
- 5. When Do Your Headaches Usually Start?**
 Constant Midday Wake Up With In Morning Evening
- 6. What Seems To Bring On Your Headaches?**
 Physical Activity Excessive Stress Caffeine Certain Foods
 Alcohol Menstrual Period Other: _____
- 7. How Often Do They Occur?**
 Daily Weekly Monthly Other: _____
- 8. How Long Do Your Headaches Last?**
 Less Than An Hour From 1-3 Hours Longer Than 3 Hours
 All Waking Hours Several Hours To Days Other: _____
- 9. Do Your Headaches Wake You From Sleep?**
 Yes No Sometimes
- 10. Do Any Of The Following Occur With Your Headaches?**
 Nausea/Vomiting Weakness Tremor Vision Problems
 Dizziness Light/Sound Sensitivity Other: _____
- 11. What Makes Your Headaches Better?**
 Nothing Rest Lying Down Ice Massage
 Standing NSAIDS (Aspirin, Tylenol, etc.) Other: _____

D. OTHER COMPLAINTS

Do You Have Any Other Complaints Not Covered On This Form? Yes No
If Yes, Describe Other Complaints In Detail

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E. REVIEW OF SYMPTOMS

Are You Currently Suffering From Any Of The Symptoms Listed Below?

- | | | | |
|---|--------------------|---------------------|---|
| <input type="checkbox"/> None of the Symptoms Listed Below
<input type="checkbox"/> General Fatigue (chronic)
<input type="checkbox"/> Weakness
<input type="checkbox"/> Fever (continuous)
<input type="checkbox"/> Loss of Sleep
<input type="checkbox"/> Chills (continuous)
<input type="checkbox"/> Weight Change (unexplained)
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Headaches
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting
<input type="checkbox"/> Convulsions
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression (Prolonged)
<input type="checkbox"/> Phobias
<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Mood Swings (excessive) | <u>Left</u> | <u>Right</u> | <input type="checkbox"/> Other: _____
<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Redness of Skin
<input type="checkbox"/> Skin Itching
<input type="checkbox"/> Skin Dryness
<input type="checkbox"/> Eczema (red, inflamed skin)
<input type="checkbox"/> Hair Changes (unplanned)
<input type="checkbox"/> Nail Changes (unplanned)
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cough (chronic)
<input type="checkbox"/> Wheezing (chronic)
<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Swollen Extremities
<input type="checkbox"/> Blue Extremities
<input type="checkbox"/> Varicosities (visible veins)
<input type="checkbox"/> Rapid Heart Beat
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Decreased Appetite
<input type="checkbox"/> Increased Appetite
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Excess Gas
<input type="checkbox"/> Vomiting (excessive)
<input type="checkbox"/> Diarrhea (excessive)
<input type="checkbox"/> Constipation (excessive)
<input type="checkbox"/> Heartburn/Indigestion
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Urinary Retention
<input type="checkbox"/> Bed-wetting
<input type="checkbox"/> Irregular Menstruation
<input type="checkbox"/> Painful Menstruation
<input type="checkbox"/> Abnormal Vaginal Bleeding
<input type="checkbox"/> Sterility
<input type="checkbox"/> Impotence
<input type="checkbox"/> Lumps in Breasts
<input type="checkbox"/> Redness/Itching of Breasts
<input type="checkbox"/> Dimpling of Breasts
<input type="checkbox"/> Discharge from Breasts
<input type="checkbox"/> Breast Pain |
|---|--------------------|---------------------|---|
-
- | | | | |
|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> Hearing Trouble
<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Pain in Ears
<input type="checkbox"/> Ear Discharge
<input type="checkbox"/> Vision Trouble
<input type="checkbox"/> Pain In Eyes
<input type="checkbox"/> Eye Discharge
<input type="checkbox"/> Nose/Sinus Pain
<input type="checkbox"/> Excessive Drainage
<input type="checkbox"/> Nose Bleeds (chronic)
<input type="checkbox"/> Nasal Infections (chronic)
<input type="checkbox"/> Absence Of Smell
<input type="checkbox"/> Mouth Sores
<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Enlarged Glands
<input type="checkbox"/> Absence of Taste
<input type="checkbox"/> Abnormal Taste Sensation
<input type="checkbox"/> Tonsillitis/Infected Tonsils
<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Heat/Cold Intolerance
<input type="checkbox"/> Sugar in Urine
<input type="checkbox"/> Goiter (enlarged thyroid gland)
<input type="checkbox"/> Tremor (shaking) | <input type="checkbox"/> | <input type="checkbox"/> | |
|---|--------------------------|--------------------------|--|

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F. HABITS/ACTIVITIES

What Are Your Current Habits?

Packs/Day

Never <1 1-2 2-3 3-4 5+

Smoking

Glasses/Day

Never <1 1-2 2-3 3-4 5+

Caffeinated Drinks.....

Glasses/Day

Never <1 1-2 2-3 3-4 5+

Alcoholic Drinks.....

Drug/Substance Abuse..... No Yes **If Yes, Discuss With Doctor**

Days/Week

Never <1 1-2 2-3 3-4 5+

Exercise.....

Kinds of Exercise You Do:

- Walking Jogging Cycling Swimming Golf
 Tennis Strength Training Other: _____

G. MEDICAL HISTORY

1. HEALTH CARE

a. **Have You Ever Been To A Chiropractor?** Yes No

b. **Do You Have A Family Physician?** Yes No

Date of Last Physical Exam: ____/____/____

Physician's Name: _____

Address: _____

c. **Have You Been Hospitalized In the Past?** Yes No

Date and Reason for Hospitalization

d. **Have You Ever Had Surgery?** Yes No

Date, Reason, Results of Surgery

e. **Have You Ever Had A Serious Accident/Injury?** Yes No

List Date & Describe Injury:

Auto: _____

Work-Related: _____

Personal: _____

Sports Injury: _____

Other: _____

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f. **Are You Currently Taking Any Vitamins, Minerals or Herbs?** (List Supplements) Yes No

g. **Are You Currently Taking Any Medications?** Yes No
 For What Condition(s) Are You Taking Medications?

Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.):

Pain/Analgesics: _____

Anti-Depressants: _____

Muscle Relaxants: _____

Blood Pressure Pills: _____

Antibiotics: _____

Birth Control Pills: _____

Corticosteroids: _____

Other: _____

In The Past Have You Used Any Of The Following?

Birth Control Pills Corticosteroids

h. **Are You Currently Allergic To Any Medications?** Yes No
 List Medications:

i. **WOMEN ONLY:** Yes No

To Your Knowledge, **Are You Pregnant?** Yes No

If Pregnant In Past, Were Pregnancies Normal? Yes No

Are You Seeing An OB-GYN Regularly? Yes No

Number of Births: 1 2 3 4 5 Other: _____

Date of Last Exam: ____/____/____

Physician's Name: _____

2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	Hypertension	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased
Father																		
Mother																		
Brother																		
Sister																		
Children																		

Describe Others: _____

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3. CONDITIONS OR ILLNESSES

Please Indicate If You Now Have Or Have Had In The Past Any Of The Following Illnesses:

No Current or Previous Conditions/Illnesses

Now Have	In Past		Now Have	In Past	
		Sinus Trouble			Kidney Trouble
		Hay Fever			Urinary Retention
		Allergies			Frequent Urination
		Emphysema			Prostate Trouble
		Tuberculosis			Arthritis
		History Of Infection			Osteoporosis
		Fever (Continuous)			Scoliosis
		Cancer/Tumor			Dislocated Joints
		Diabetes			Spinal Disc Disease
		Visual Disturbances			Bone Fractures (list/dates):
		Dizziness/Fainting			_____
		Epilepsy/Seizures			_____
		Thyroid Trouble			Mental/Emotional Difficulty
		High Blood Pressure			Sex. Trans. Disease
		Low Blood Pressure			HIV
		Heart Trouble			AIDS/ARC
		Pacemaker			Abnormal Weight Gain
		Stroke (date): ___/___/_____			Abnormal Weight Loss
		Aortic Aneurism			Numbness Groin/Buttocks
		Anemia			Other: _____
		Rheumatic Fever			_____
		Polio			_____
		Multiple Sclerosis			Other: _____
		Ulcer			_____
		Liver Trouble			_____

H. OCCUPATIONAL INFORMATION/ACTIVITIES OF DAILY LIVING

1. Are You Right Or Left Handed? Right Left
2. Occupation: _____
3. Hours Per Week: _____
4. How Long Have You Been In This Occupation?
 Years 10 20 30 40 50
 1 2 3 4 5 6 7 8 9
5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day? Yes No

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6. What Is Your Primary Work Position And Location?

Work Position: Work Location:
 Seated Standing Desk Counter Workbench
 Other: _____ Other: _____

7. What Movements Does Your Job Require?

Bending Turning Stooping Twisting
 Walking Repetitive Hand Use Carrying
 Other: _____

8. Does Your Job Involve Lifting?

Never Occasionally Intermittently Frequently Constantly
How Many Pounds? <10 10-25 26-50 51-75 76-100 100+

9. What Best Describes Your Stress Level At Work?

None Minimal Moderate Extreme

10. How Do You Rate Your Physical Activity At Work?

Light Moderate Heavy

11. Do Your Work Activities Aggravate Your Current Complaint(s)?

Yes No If Yes, Explain: _____

Patient's Signature

_____/_____/_____
Date