CHIROPRACTIC SOLUTIONS

by dr julie

HEALTH HISTORY QUESTIONNAIRE

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

DATE:		**Signature:**	
Name *(Last, First, M.I.):*		☐ **M** ☐ **F**	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**Age:**
Occupation:		**Email:**	
Medical Doctor:		**Phone Number:**	

TODAY'S COMPLAINT:

What brings you here for examination?	
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)? Who? Name & Number:	
What treatment was provided?	
What were the results?	
What aggravates this/these condition(s)?	
Are your symptoms getting worse?	
What makes the condition better?	
Any associated conditions?	

PERSONAL HISTORY:

List any medical problems that other doctors have diagnosed, surgeries, or hospitalizations:

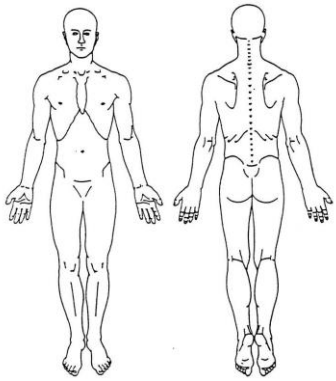
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

List any traumas, fractures, accidents, injuries, or falls, including auto accidents. Provide date:

List any sports/hobbies that you currently or previously engaged:

13125 Eastpoint Park Blvd, Suite 105 Louisville, KY 40223
Dr. Julie L. Lyles Phone: 502/253-1135 Fax: 502/253-1136

Mark with "x" for local pain, "---" for shooting pain, "0" for numbess or tingling, "*" for weakness.



Check if you have/have had any symptoms in the following areas to a significant degree/briefly explain.		
☐ Headaches	☐ Mid Back Pain	☐ Ringing in the ears
☐ Neck Pain	☐ Mid Back Stiffness	☐ Frequent Sinus Infections
☐ Neck Stiffness	☐ Low Back Pain	☐ Constipation/Poor Digestion
☐ Shoulder Pain/Stiffness	☐ Low Back Stiffness	☐ Frequent Urination
☐ Arm Pain	☐ Leg Pain	☐ Dizziness
☐ Arm Tingling/Numbness	☐ Leg Tingling/Numbness	☐ Asthma
☐ Wrist Pain/Weakness	☐ Ankle Pain/Weakness	☐ Cancer
☐ Hand Pain/Stiffness	☐ Foot Pain/Stiffness	☐ Diabetes
☐ Muscle Soreness	☐ Muscle Spasms	☐ Arthritis
☐ WOMEN: Menstrual Problems	☐ MEN: Prostate Problems	☐ Sexual Dysfunction
Recent changes in:		
☐ Weight	☐ Mood	☐ Flexibility
☐ Energy level	☐ Ability to sleep	☐ Other pain/discomfort:

FAMILY HISTORY:

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

HEALTH HABITS AND PERSONAL SAFETY

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

Exercise	☐ Sedentary (No exercise)		☐ Mild exercise (climb stairs, walk 3 blocks, golf)	
	☐ Occasional Vigorous Exercise (less than 4x/week for 30 minutes)		☐ Regular vigorous exercise (4x/week for 30 minutes)	
Diet	Are you dieting? ☐ Yes ☐ No	If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol? ☐ Yes ☐ No	Are you concerned about the amount you drink? ☐ Yes ☐ No		
	Do you drive after drinking? ☐ Yes ☐ No			
Tobacco	Do you use tobacco? ☐ Yes ☐ 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? ☐ Yes ☐ No			

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