Patient Name_____Date_____

Vitae Chiropractic | 5481 W 7800 S Unit 110 | West Jordan, UT 84081 | (435) 562-1513

Health History Questionnaire

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

Date:	**Name:**	**Date of Birth:**
Address:		**Phone:**
Email:		**Sex (circle): Male Female Non-binary/Other**
Marital Status: Married Single Divorced Widowed		**Occupation:**
Emergency Contact/relation/phone number:		**How did you find our office:**

Current Problems

Where is your current pain?

1. _____
2. _____
3. _____

When did you first notice your problem?

1. _____
2. _____
3. _____

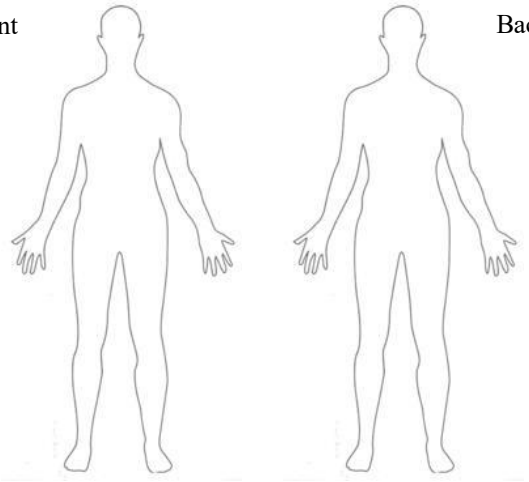
Have you experienced previous episodes?

1. _____
2. _____
3. _____

Are your symptoms constant or intermittent?

1. _____
2. _____
3. _____

Front Back



Doctors Notes:

What makes it better?

1. _____
2. _____
3. _____

What makes it worse?

1. _____
2. _____
3. _____

Please answer the following questions on a scale from 0-10
(0 being no pain and 10 being worst pain imaginable)

What is your current pain severity? 1. _____ 2. _____ 3. _____
What is your pain on average? 1. _____ 2. _____ 3. _____
What is your pain at its worse? 1. _____ 2. _____ 3. _____

Patient Name_____Date_____

Please describe the quality of your pain (circle all that apply)

1. Sharp Dull Tingling Achy Numb Stabbing Burning Stiff Tight Sore
2. Sharp Dull Tingling Achy Numb Stabbing Burning Stiff Tight Sore
3. Sharp Dull Tingling Achy Numb Stabbing Burning Stiff Tight Sore

Does your pain spread to any other areas? (Circle all that apply)

Neck Mid-Back Low-Back Arms Legs Shoulders Head Other: _____

Family Health History

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	□ M □ F	
Mother				□ M □ F	
Sibling		□ M □ F		□ M □ F	
		□ M □ F		□ M □ F	

Personal Health History

List any medical problems other doctors have diagnosed: _____

_____

_____

List any doctors/physicians that are currently treating you as well: _____

_____

_____

Surgeries		
Year	Reason	Any lasting/residual effects?
Accidents/ Hospitalizations		
Year	Reason	Any lasting/residual effects?

Patient Name_____Date_____

Current Medications

List your prescribed drugs and over the counter drugs such as vitamins and inhalers.

Name of Drug/Vitamin	Strength/Dose	Frequency Taken	Reason for Taking

Review of Symptoms

Check if you have had significant problems with any of the following areas:

Skin	□	Dizziness	□	Cold Extremities	□	Ability to Sleep	□
Head/Neck	□	Nose Bleeds	□	Muscle cramps	□	Bowel	□
Weight	□	Chest/Heart	□	Headaches	□	Change in Appetite	□
Digestion	□	Back	□	Ringing in Ears	□	Shortness of Breath	□
Nose	□	Ears	□	Lungs	□	Bleeding/bruising easily	□
Vision	□	Energy Level	□	Circulation	□	JAW/TMJ Pain	□
Fatigue	□	Bladder	□	Throat	□	High Blood Pressure	□
Fever/Chills	□	Hearing	□				

Women Only:

Number of pregnancies? _____ Number of live births: _____	
Are you currently pregnant or breastfeeding?	□ Y □ N
Have you a D&C, hysterectomy, or Cesarean?	□ Y □ N
Any urinary tract, bladder, or kidney infections within the last year?	□ Y □ N
Any hot flashes or sweating at night?	□ Y □ N
Do you have menstrual tension, pain, bloating, irritability, or other symptoms around time of period?	□ Y □ N
Heavy periods, irregularity, spotting, pain, or discharge?	□ Y □ N

Health Habits & Personal Safety

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

Exercise	□ Sedentary (no exercise) □ Mild Exercise (i.e. climb stairs, walk 3 blocks, golf) □ Occasional Exercise (i.e. work or recreation, less than 4x/week for 30 min.) □ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)	
Diet	Are you dieting or restrict certain foods?	□ Y □ N
	# of meals you eat in an average day?	

Patient Name_____Date_____

Caffeine	□ None □ Coffee □ Tea □ Cola	
Alcohol	Do you drink alcohol?	□ Y □ N
	How many drinks per week?	
Tobacco	Do you currently use tobacco?	
	□ Cigarettes ____ /day □ Chew____ /day □ Pipe ____ / □ Cigars _____/day	□ Y □ N
	Have you used tobacco in the past?	
	_____ number of years _____ year quit	□ Y □ N
Drugs	Do you currently use recreational or street drugs?	□ Y □ N
Stress	Do you have a stress coping mechanism If yes, please explain:	
Water	How much water do you drink per day?	
Sleep	How many hours a night do you sleep?	
	Do you feel rested when you wake?	□ Y □ N
	How old is your mattress?	

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition.

Patient Signature: _____ Date: _____