



*Carriage House Chiropractic and
Acupuncture*

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Chiropractic Patient History Questionnaire

Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: (home) _____ (cell) _____ (work) _____

May we leave phone messages for you at the above phone numbers? Yes No

May we send appointment reminders to you via text messages on your cell phone for? Yes No

Email: _____

May we contact you via mail or email with newsletters/special offers? Yes No

May we contact you via email regarding your care? Yes No

How did you hear about our practice: _____

Gender: M F Birthdate: ____/____/____ Age: ____

Single Married/Partnership Divorced Widowed Separated

Spouse/Partner Name: _____

Emergency Contact: _____ Phone: _____

Occupation: _____ Employer: _____

Name of Primary Care Physician (PCP): _____ Phone: : _____

PCP's Address: _____ City: _____ St: _____ Zip: _____

Insurance Company Name: _____ ID #: _____

Name of Subscriber: _____ His/Her Date of Birth: ____/____/____

What CHCAA services/products interest you in meeting your health goals?

- ____ Chiropractic ____ Soft Tissue Techniques ____ Graston Technique ____ Ergonomics
- ____ Exercises ____ Supplements/Vitamins ____ Nutritional Counseling ____ Acupuncture
- ____ Homeopathy ____ PowerLift Training ____ Other (please describe below):

What complaint brings you in today? _____

Have you seen any other providers for today's complaint(s)? **Yes No** If yes, list their name and specialty:

What types of treatment(s) have you received, if any, for your presenting complaint(s)? **None**

Have you had any tests (X-rays, MRI, CT, Lab work) for this or other current complaint(s)? **Yes No** If yes, describe:

Please complete the following for your complaint.

Please rate your symptoms on a scale of 0-10 (10 being the most severe symptoms you've ever experienced):

(circle) **No Symptoms 1 2 3 4 5 6 7 8 9 10 Worst Symptoms**

How often do you have the symptoms?: (circle)

Occasionally (0-25% of the time) Intermittently (26-50%) Frequently (51-75%) Constantly (75-100%)

Please describe the symptoms you are feeling?: (circle)

Sharp/Stabbing Ache Dull Burning Throbbing Numbness Tingling Cramping

What caused the symptoms?: _____

When did the symptoms start?: _____

What makes the symptoms worse?: _____

What makes the symptoms better?: _____

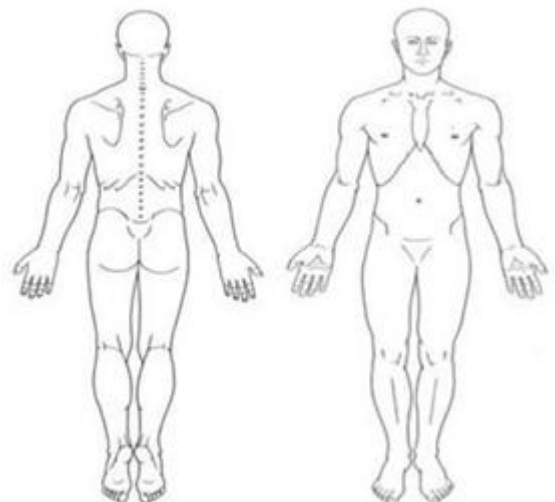
Do the symptoms travel? _____ If so, where?: _____

Are the symptoms worse at any particular time of day?: _____

Date of same or similar symptoms ____/____/____

To help us better understand the nature & origin of your complaints, please complete this drawing. Use the symbols listed below to detail where you hurt and how you hurt.

- ////////// Dull Ache/Throb
- XXXXXX Sharp/Stabbing
- BBBBBB Burning
- OOOOOO Numbness
- Tingling
- CCCCCC Cramping



Overall Health

Please list other medical/health problems you may be seeing other providers for: (Please list issue and provider.)

Have you ever had X-rays, MRI or CT or any other tests (e.g., EKG, blood work) for the other medical problems you are being treated for? **Yes No** If yes, list below:

Study/Test: _____ Date: _____ Treatment received: _____

Study/Test: _____ Date: _____ Treatment received: _____

Have you ever been hospitalized or had surgery? **Yes No** If yes, please describe:

What medications, supplements and vitamins are you currently taking? (please include dosages)

Please check the following if you are currently taking or have taken in the past three months:

- vitamins
- pain medicine
- insulin
- blood vessel drugs
- cold/cough medicine
- herbs
- anti-depressants
- cortisone/steroids
- blood thinners
- hormone replacements
- laxatives
- weight loss pills
- heart medications
- beta blockers
- stomach/GI reflux medicine
- muscle relaxants
- thyroid medication
- blood pressure medication
- birth control pills

Please check the following conditions that you have or have had:

- Anemia
- Parkinson’s Disease
- Heart attack
- Polio
- Arthritis
- High blood pressure
- Rheumatic fever
- AIDS
- Cancer
- Low blood sugar
- Stroke
- Epilepsy
- Diabetes
- Multiple sclerosis
- Tuberculosis

Allergies

Please list all allergies (Seasonal, Food, Medications): _____

Female Only

Are you pregnant?/Is there a chance that you are pregnant? **Yes No**

Office Use Only: _____

Please fill in the bubble(s) according to the following rating system:

Ⓜ: Occurred within the last week Ⓞ: Occurred within the last month Ⓨ: Occurred within the last year

Head

- Ⓜ Ⓞ Ⓨ Frequent headaches
- Ⓜ Ⓞ Ⓨ Unusually severe headaches
- Ⓜ Ⓞ Ⓨ Previous head trauma
- Ⓜ Ⓞ Ⓨ Head feels heavy
- Ⓜ Ⓞ Ⓨ Light headedness
- Ⓜ Ⓞ Ⓨ Facial Numbness
- Ⓜ Ⓞ Ⓨ Vertigo
- Ⓜ Ⓞ Ⓨ Loss of balance

Neck

- Ⓜ Ⓞ Ⓨ Neck pain with movement
- Ⓜ Ⓞ Ⓨ Dizziness with movement
- Ⓜ Ⓞ Ⓨ Neck feels out of place
- Ⓜ Ⓞ Ⓨ Stiff neck
- Ⓜ Ⓞ Ⓨ Swelling in neck
- Ⓜ Ⓞ Ⓨ Muscle spasms in neck
- Ⓜ Ⓞ Ⓨ Pinched nerve in neck
- Ⓜ Ⓞ Ⓨ Previous neck injury

Shoulders

- Ⓜ Ⓞ Ⓨ Pain in shoulder
(right or left)
- Ⓜ Ⓞ Ⓨ Muscle spasms in
shoulders
- Ⓜ Ⓞ Ⓨ Pain across shoulders
- Ⓜ Ⓞ Ⓨ Tension in shoulders
- Ⓜ Ⓞ Ⓨ Can't raise arm over head
- Ⓜ Ⓞ Ⓨ Can't raise arm above
shoulder level

Arms & Hands

- Ⓜ Ⓞ Ⓨ Pain in upper arm
- Ⓜ Ⓞ Ⓨ Pain in forearm
- Ⓜ Ⓞ Ⓨ Pain in hands
- Ⓜ Ⓞ Ⓨ Pain in fingers
- Ⓜ Ⓞ Ⓨ Fingers go to sleep
- Ⓜ Ⓞ Ⓨ Cold hands
- Ⓜ Ⓞ Ⓨ Swollen finger joints
- Ⓜ Ⓞ Ⓨ Sore finger joints
- Ⓜ Ⓞ Ⓨ Loss of grip strength
- Ⓜ Ⓞ Ⓨ Pins and needles

Low Back

- Ⓜ Ⓞ Ⓨ Low back pain
- Ⓜ Ⓞ Ⓨ Low back out of place
- Ⓜ Ⓞ Ⓨ Muscle spasms in low back

Mid Back

- Ⓜ Ⓞ Ⓨ Pain between shoulder
blades
- Ⓜ Ⓞ Ⓨ Muscle spasms in mid
back
- Ⓜ Ⓞ Ⓨ Pain over kidney area
- Ⓜ Ⓞ Ⓨ Mid back pain
- Ⓜ Ⓞ Ⓨ Pain below shoulder blades
w/exercise
- Ⓜ Ⓞ Ⓨ Pain from front to back

Hips, Legs, & Feet

- Ⓜ Ⓞ Ⓨ Pain in buttocks
- Ⓜ Ⓞ Ⓨ Pain down leg
- Ⓜ Ⓞ Ⓨ Cold feet
- Ⓜ Ⓞ Ⓨ Knee pain
- Ⓜ Ⓞ Ⓨ Leg cramps
- Ⓜ Ⓞ Ⓨ Swollen ankles
- Ⓜ Ⓞ Ⓨ Pins and needles
- Ⓜ Ⓞ Ⓨ Numbness in legs or toes
- Ⓜ Ⓞ Ⓨ Swollen feet

Cardiovascular

- Ⓜ Ⓞ Ⓨ Chest pain
- Ⓜ Ⓞ Ⓨ Fainting
- Ⓜ Ⓞ Ⓨ Pounding heartbeat
- Ⓜ Ⓞ Ⓨ Heart "jumps"
- Ⓜ Ⓞ Ⓨ Rapid heartbeat
- Ⓜ Ⓞ Ⓨ Irregular heartbeat
- Ⓜ Ⓞ Ⓨ Blue skin
- Ⓜ Ⓞ Ⓨ High blood pressure
- Ⓜ Ⓞ Ⓨ Poor circulation
- Ⓜ Ⓞ Ⓨ Heart murmurs

Ears

- Ⓜ Ⓞ Ⓨ Loss of hearing
- Ⓜ Ⓞ Ⓨ Pain in ears
- Ⓜ Ⓞ Ⓨ Discharge from ears
- Ⓜ Ⓞ Ⓨ Vertigo
- Ⓜ Ⓞ Ⓨ Ringing in ears

Eyes

- Ⓜ Ⓞ Ⓨ Blurred vision
- Ⓜ Ⓞ Ⓨ Double vision
- Ⓜ Ⓞ Ⓨ Eyes fatigue easily
- Ⓜ Ⓞ Ⓨ Excessive tearing
- Ⓜ Ⓞ Ⓨ Lack of tearing
- Ⓜ Ⓞ Ⓨ Light bothers eyes
- Ⓜ Ⓞ Ⓨ Pain in eyeball (s)
- Ⓜ Ⓞ Ⓨ Periods of blindness in
eyes
- Ⓜ Ⓞ Ⓨ Red eyes
- Ⓜ Ⓞ Ⓨ Night blindness
- Ⓜ Ⓞ Ⓨ Pain behind eyes

Nose/Nasopharynx/Sinuses

- Ⓜ Ⓞ Ⓨ Unusual nasal discharge
- Ⓜ Ⓞ Ⓨ Nose bleeds
- Ⓜ Ⓞ Ⓨ Pressure over eyes
- Ⓜ Ⓞ Ⓨ Pressure under eyes
- Ⓜ Ⓞ Ⓨ Sinusitis/Nasal allergies
- Ⓜ Ⓞ Ⓨ Any trauma to nose

Mouth & Throat

- Ⓜ Ⓞ Ⓨ Pain in mouth
- Ⓜ Ⓞ Ⓨ Pain in throat
- Ⓜ Ⓞ Ⓨ Bleeding gums
- Ⓜ Ⓞ Ⓨ Abscessed teeth
- Ⓜ Ⓞ Ⓨ Difficulty swallowing

Hair, Skin, & Nails

- Ⓜ Ⓞ Ⓨ Dry/Oily scalp
- Ⓜ Ⓞ Ⓨ Allergies to Chlorine
- Ⓜ Ⓞ Ⓨ Psoriasis
- Ⓜ Ⓞ Ⓨ Itchy skin
- Ⓜ Ⓞ Ⓨ Rough, scaly scalp
- Ⓜ Ⓞ Ⓨ Sensitive skin
- Ⓜ Ⓞ Ⓨ Dry or Oily skin
- Ⓜ Ⓞ Ⓨ Yellow skin
- Ⓜ Ⓞ Ⓨ Bruise easily
- Ⓜ Ⓞ Ⓨ Pale skin
- Ⓜ Ⓞ Ⓨ Rashes
- Ⓜ Ⓞ Ⓨ Eczema
- Ⓜ Ⓞ Ⓨ Skin cancer
- Ⓜ Ⓞ Ⓨ Nail biting

Office Use Only: _____

Please fill in the bubble(s) according to the following rating system:

Ⓜ: Occurred within the last week Ⓞ: Occurred within the last month Ⓨ: Occurred within the last year

Gastrointestinal

- Ⓜ Ⓞ Ⓨ Poor appetite
- Ⓜ Ⓞ Ⓨ Constant nibbling
- Ⓜ Ⓞ Ⓨ Indigestion
- Ⓜ Ⓞ Ⓨ Stomach upsets from food/liquid
- Ⓜ Ⓞ Ⓨ Abdominal pains
- Ⓜ Ⓞ Ⓨ Stomach upsets from medicines
- Ⓜ Ⓞ Ⓨ Stomach gas before/after meals
- Ⓜ Ⓞ Ⓨ Stomach gas with meals
- Ⓜ Ⓞ Ⓨ Change in bowel habits
- Ⓜ Ⓞ Ⓨ Diarrhea
- Ⓜ Ⓞ Ⓨ Constipation
- Ⓜ Ⓞ Ⓨ Hemorrhoids
- Ⓜ Ⓞ Ⓨ Jaundice
- Ⓜ Ⓞ Ⓨ Ulcers
- Ⓜ Ⓞ Ⓨ Liver disease
- Ⓜ Ⓞ Ⓨ Hepatitis
- Ⓜ Ⓞ Ⓨ Loss of bowel control
- Ⓜ Ⓞ Ⓨ Gall bladder disease

Respiratory

- Ⓜ Ⓞ Ⓨ Shortness of breath
- Ⓜ Ⓞ Ⓨ Asthma
- Ⓜ Ⓞ Ⓨ Chronic cough
- Ⓜ Ⓞ Ⓨ Difficulty breathing
- Ⓜ Ⓞ Ⓨ Dry cough
- Ⓜ Ⓞ Ⓨ Wheezing
- Ⓜ Ⓞ Ⓨ Difficulty sleeping while lying down
- Ⓜ Ⓞ Ⓨ Productive cough
- Ⓜ Ⓞ Ⓨ Coughing up blood

Genitourinary

- Ⓜ Ⓞ Ⓨ Frequent Urination
- Ⓜ Ⓞ Ⓨ Infrequent Urination
- Ⓜ Ⓞ Ⓨ Urination – High Volume
- Ⓜ Ⓞ Ⓨ Urination – Low Volume
- Ⓜ Ⓞ Ⓨ Up at night to urinate
- Ⓜ Ⓞ Ⓨ Blood in urine
- Ⓜ Ⓞ Ⓨ Difficult to start/stop
- Ⓜ Ⓞ Ⓨ Painful urination
- Ⓜ Ⓞ Ⓨ Incontinence
- Ⓜ Ⓞ Ⓨ Stream flow abnormality
- Ⓜ Ⓞ Ⓨ Lack of bladder control
- Ⓜ Ⓞ Ⓨ Back pain with urination
- Ⓜ Ⓞ Ⓨ Cloudy urine

Male Only

- Ⓜ Ⓞ Ⓨ Impotence
- Ⓜ Ⓞ Ⓨ Testicular swelling/pain
- Ⓜ Ⓞ Ⓨ Testicular masses
- Ⓜ Ⓞ Ⓨ Blood in sperm
- Ⓜ Ⓞ Ⓨ Prostate disease

Female Only

Date of last period _____

_____ # of days in cycle

_____ # of pregnancies

_____ # of deliveries

_____ # of vaginal deliveries

_____ # of C-sections

- Ⓜ Ⓞ Ⓨ Painful periods
- Ⓜ Ⓞ Ⓨ Missed menstrual periods
- Ⓜ Ⓞ Ⓨ Irregular cycles
- Ⓜ Ⓞ Ⓨ Spotting
- Ⓜ Ⓞ Ⓨ Vaginal discharge
- Ⓜ Ⓞ Ⓨ PMS symptoms
- Ⓜ Ⓞ Ⓨ Lumps in breasts
- Ⓜ Ⓞ Ⓨ Wear an IUD
- Ⓜ Ⓞ Ⓨ LBP w/ menses
- Ⓜ Ⓞ Ⓨ Complicated deliveries
- Ⓜ Ⓞ Ⓨ LBP w/ pregnancy
- Ⓜ Ⓞ Ⓨ Fibroid tumors
- Ⓜ Ⓞ Ⓨ Ovarian cysts
- Ⓜ Ⓞ Ⓨ Nipple discharge
- Ⓜ Ⓞ Ⓨ Excessive menstrual flow

What are your goals for care?

Office Use Only: _____

Family History

Do you have any children? **Yes No** If yes, please list their gender(s) and age(s): _____

Do your children have any major medical problems (past or present)? **Yes No** If yes, please describe:

Do you have any siblings? **Yes No** Do/did they have any major medical problems? **Yes No**
If yes, please describe: _____

Are your parents still living? **Yes No** Do/did they have any major medical problems? **Yes No**
If yes, please describe: _____

Are your grandparents still living? **Yes No** Do/did they have any major medical problems? **Yes No**
If yes, please describe: _____

General Health Questions

Do you use tobacco products? **Yes No** If yes, what type? : _____

How much? _____ How long? _____ Have you ever tried quitting? **Yes No**

If you quit, when? _____ Why?: _____

Drink Alcoholic Beverages? **Yes No** If yes, how much do you drink per week?: _____

Have a history significant for recreational drug use? **Yes No** If yes, describe: _____

My diet is: **balanced not balanced.** My recreation is: **sufficient insufficient.**

My rest is: **sufficient insufficient.** My family stress is: **severe moderate minimal none.**

How do you like your work? **above average average below average N/A.**

My job stress is: **severe moderate minimal none N/A.**

Thank you for completing this form. The information you have provided will help us in attending to your healthcare needs.

I have read and completed all answers to the above questions to the best of my knowledge. I understand that failure to properly disclose all appropriate health history may hinder my health care provider’s ability to properly diagnose and treat my complaints. I will, on all future visits, inform my health care provider of changes in my health status.

Your signature _____ Date _____

Provider’s signature _____ Date _____