Wood Family Chiropractic
Initial Evaluation Questionnaire

Name ____________________________________ **Date** ________________

Health Complaints You Want Help With (#1 most important - #5 least important)

1. ________________________________ When did it start? ________________
2. ________________________________ When did it start? ________________
3. ________________________________ When did it start? ________________
4. ________________________________ When did it start? ________________
5. ________________________________ When did it start? ________________

Referring Physician or Facility ____

Additional Physician(s)

Doctor's Name ____________________________ For What Condition __________________

Doctor's Name ____________________________ For What Condition __________________

Doctor's Name ____________________________ For What Condition __________________

_____ Please check here if you ran out of room and continue this section on the back of this page.

Past Medical History (Please check if you have or have had any of the following)

_____ High Blood Pressure _____ Arthritis _____ Ulcer/Reflux Disease

_____ Irregular Heartbeat _____ Herniated Disc _____ Degenerative Disc Disease

_____ Stroke _____ Spinal Stenosis _____ Peripheral Vascular Disease

_____ Back Pain/Neck Pain _____ Diabetes _____ Heart Failure/Heart Attack

_____ Blood Clots _____ Cancer

Other Significant Medical History ____

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Initial _____

Initial _____

Family History
(Please list all that apply to **blood relatives** -father, mother, father's parents, mother's parents and siblings)

______ High Blood Pressure ______ Diabetes ______ Heart Disease

______ Anxiety/Depression ______ Cancer - Type?______________________

______ Kidney Disease ______ Thyroid Disease ______ High Cholesterol

______ Stroke ______ Bleeding Disorder ______ Arthritis (RA/OA)

If Blood Relative is Deceased, Please Indicate Cause and Age of Death ___________________

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Other Significant Family Diseases ____

Do You Have a Pacemaker? Yes No Do You Have a Defibrillator? Yes No

Do You Have any Surgical Devices or metal in Your Body? Yes No (Example: Pins, Plates, Screws, etc.)
If Yes, Please Specify Location ____________________________

Past Hospitalizations and/or Surgeries

Procedure or Reason ____________________________ Date of Procedure ___________

Procedure or Reason ____________________________ Date of Procedure ___________

Procedure or Reason ____________________________ Date of Procedure ___________

Procedure or Reason ____________________________ Date of Procedure ___________

______ Please check here if you ran out of room and continue this section on the back of this page.

Social History

Smoking Yes No Alcohol Yes No Occupation _____________________
Hobbies and Other Activities ____

Marital Status: ____

Initial _____

Medications (Please indicate name, for what condition and how often you take it)
If you brought a list of your prescriptions, please indicate by writing, “See Rx Sheet” below

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Allergies (Please indicate if allergy is due to medications or other)

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Current Nutritional Supplements
(Please indicate name, for what condition and how often you take it)

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Initial _____

Review of Systems

(Please indicate below any symptoms that you've experienced within the last 6 months)

GENERAL
- Fever
- Chills
- Weakness
- Night Sweats
- Weight Gain
- Weight Loss
- Loss of Appetite
- Fatigue
- Loss of Sleep

CARDIOVASCULAR
- Chest Pain
- Angina
- Murmur
- Irregular Heart Beat
- Palpitations
- Extremity Swelling
- Varicose Veins
- Pain with Walking
- Cold Hands or Feet
- High Cholesterol
- High Triglycerides
- High Blood Pressure
- Heart Attacks
- Congestive Heart Failure
- Atherosclerosis

GENITOURINARY
- Frequent Urination
- Difficulty Controlling Urination
- Blood in Urine
- Pain with Urination
- Passage of Stones

ENDOCRINE
- Heat/Cold intolerance
- Thyroid Disease
- Thyroid Removed
- Goiter
- Decreased Energy
- Hands/Feet Cold
- Diabetes Type I or II
- Heat Intolerance
- Adrenal Disease
- Kidney Disease
- Kidney Stones

HEAD
- Headache
- Trauma
- Dizziness
- Vertigo

RESPIRATORY
- Shortness of Breath
- Wheezing/Asthma
- Sputum Production
- Night Sweats
- Cough
- Coughing up Blood
- COPD/Emphysema
- Bronchitis

SKIN/HAIR
- Rash
- Pruritus
- Moles
- Cancer
- Dryness
- Acne
- Eczema
- Psoriasis
- Hair Loss
- Hives
- Rash

BLOOD/LYMPH
- Anemia
- Blood Thinner
- Easy Bruising
- Easy Bleeding
- Lymph Node Swelling
- Lymph Node Pain

ENDOCRINE (MALE)
- Erection Issues
- Prostate Cancer
- Prostate Enlarged
- Sexual Desire Diminished
- UTI's
- Urinary; Dribble, Hesitancy, Frequency

EYES
- Double Vision
- Blurred Vision
- Cataracts
- Discharge
- Glaucoma
- Watery Eyes

GASTROINTESTINAL
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Ulcer
- Blood in Stool
- Abdominal Pain
- Hernia
- Hemorrhoids
- Change in Appetite
- Anal or rectal pain/itching
- Bloating/belching/gas
- Gall Stones
- Reflux
- Hepatitis/Liver Disease
- IBS
- Elevated Liver Enzymes

MUSCULOSKELETAL
- Muscle Pain
- Muscle Spasm
- Muscle Atrophy
- Back Pain/Stiffness
- Neck Pain/Stiffness
- Joint Pain
- Joint Stiffness
- Weakness
- Fractures
- Carpal Tunnel Syndrome
- Neuropathy
- Osteoporosis/Osteopenia
- Sciatica

ALLERGY/IMMUNOLOGIC
- Sinusitis
- Seasonal Allergies
- Allergy Shots
- Cancer (type: __________)
- Diabetes Type I
- Hashimoto's Thyroiditis
- Grave's Disease
- Lupus
- Multiple Sclerosis
- Rheumatoid Arthritis

ENT
- Loss of Hearing
- Discharge
- Loss of Smell
- Congestion
- Dentures
- Sores
- Gingival Bleeding
- Hoarseness
- Sore Throat
- Difficulty Swallowing
- Jaw Pain

ENDO-GYNECOLOGIC
- Self-Exam
- Masses/Lumps
- Vaginal Discharge
- Nipple Discharge
- Infertility
- Menstruation Irregular
- Painful Intercourse
- PCOS
- Premenstrual Syndrome
- Painful Menstruation
- Fibroid Tumor
- Yeast Infections
- UTI's recurrent
- Bleeding Between Periods
- Endometriosis
- Hot Flashes
- Loss of Sex Drive
- Vaginal Dryness

PSYCHIATRIC
- Anxiety
- Depression
- Hallucinations
- Sleep Disturbance
- Body Image Concerns
- Cravings
- Eat When Nervous
- High Stress
- Mood Swings
- Phobias

NEUROLOGIC
- Loss of Consciousness
- Fainting
- Numbness
- Weakness
- Tingling
- Seizures

Initial _____

Date of Last Mammogram or Breast Thermography _______________ N/A

Date of Last Menstrual Period _______________ N/A

Date of Last Pelvic Examination ______________ N/A

How Would You Rate Your Stress Level? 1 2 3 4 5 6 7 8 9 10 (1=very low, 10=very high)

How does stress affect you? 1 2 3 4 5 6 7 8 9 10 (1=doesn't bother me, 10=it really affects me)

How often do you exercise? Never Rarely Sometimes Regularly Competitively

Is your exercise limited due to any problems with your body? (i.e., pain, fatigue, breathing, etc)
Yes No If Yes, please explain ____

How well do you sleep? (circle all that apply)
Very Well Trouble falling asleep Trouble staying asleep Insomnia Sleep Apnea

How Long has this been happening? ___________________________________

How many hours do you sleep per night on average? __________

Do you wake up tired, even if you slept several hours? Yes No How long has this occurred? __________

Do Night Sweats wake you up? Yes No

Do you wake because you have to urinate? Yes No

Do you take sleep aids? Yes No If Yes, how often? ________________________

Have You Had a Bone Density Study? Yes No If Yes, Please Note Findings, Date and Facility ____

Have You Ever Had Joint Injections or Trigger Point Injections? Yes No If Yes, Please Specify and Record Location ____

Have You Tried Unsuccessfully to Lose Weight in the Past? Yes No If Yes, What Have You Tried? ____

Have You Been Told That You Will Need Knee Replacement Surgery? Yes No

Initial _____

Comments

Please use the area below to communicate anything that you think is important for us to know regarding your health and your health goals

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Signature

I certify that the information I have provided Wood Family Chiropractic is answered accurately to the best of my ability. I will not hold any doctors, or members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ______/______/______

Patient or Guardian Signature/Parent or Guardian Signature (if patient is under 18 years of age) Date

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Printed name