

PATIENT QUESTIONNAIRE

Date: _____
Name: _____
Street: _____
City: _____
State: _____ ZIP: _____
Res. Phone: () _____
Bus. Phone: () _____
Cell Phone: () _____
Email: _____
Social Security #: _____
Occupation: _____
Date of Birth: _____
Sex: M F Age: _____
If child, parent's name: _____
Marital Status: M W S D
Spouse Name: _____
No. of Children: _____ Ages: _____
If you have had any of the following, please describe:
Accidents: _____

Date of Last Physical Exam: _____
Physician: _____
Purpose: _____
Surgery & dates: _____
Serious illnesses & dates: _____
Fractured bones & dates: _____
Vaccinations: _____
Have you been under Chiropractic care? Y N
Dr.'s Name: _____
Referred to Dr. Holze by: _____

Events Preceding Onset: _____

Present Complaint or Illness: _____

How long since you've been well? _____
If not accident related, date illness began: _____

Is condition due to auto accident or personal injury? Y N

Is condition due to injury or sickness arising from work? Y N

Personal Health Goals: _____

Patient ever had same or similar conditions? Y N

If yes, when? _____
Describe: _____

WOMEN ONLY:

Onset menstruation: _____ No. of children: _____

Complications: _____ No. of miscarriages: _____

C-sections: _____ Menopause: _____
Form of Birth Control: None Pill IUD Sponge Diaphragm Foam Other
Date of last period: _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your Work Sleep Routine Other: _____

How long has it been since you really felt well? _____

Do you have the encouragement of your family in pursuing this form of health care? Yes No

What do you believe is wrong with you? _____

What specific services do you expect from this office? _____

Other Doctors seen for this condition: _____

Have you been treated for any health conditions by a physician in the last year? Yes No

Please describe: _____

What medications both prescription and over the counter are you now taking? _____

What medications both prescription and over the counter have you taken in the past? _____

List all forms of mechanical (trauma), chemical (toxins), and mental stress have you exposed to as pertaining to your employment of lifestyle: _____

Any comments, problems, etc., that you wish to communicate to the Doctor? Please feel free to write and all things you feel important to your health and well being. _____

Circle all those that you eat, drink or use:

- Alcohol
- Candy
- Carbonated beverages
- Cigarettes
- Coffee
- Distilled water
- Fast food (regularly)
- Fried foods
- Luncheon meat
- Margarine
- Refined sugars
- Saccharine (Sweet and Low)
- Chew tobacco
- Vitamins and/or minerals (please list)

Relatives	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Gout	Heart Disease/Stroke	High Blood Pressure	Hyphthyroidism	Kidney Disease	Neurological Disease	Periodontal Disease	Tuberculosis	Atherosclerosis	Obesity	Senility
You																	
Father																	
Mother																	
Brothers																	
Sisters																	
Spouse																	
Children																	
Grandparents																	

Check any other illnesses which you now have or have had. Please indicate the year you have had these.

- | | | | | |
|---------------------------|--------------------------------|---------------------------|--------------------------|----------------------------|
| _____ Abcesses | _____ Chicken pox | _____ Gingivitis | _____ Low blood pressure | _____ Pneumonia |
| _____ Acne | _____ Cirrhosis | _____ Goiter | _____ Lupus | _____ Polio |
| _____ AIDS | _____ Crohn's disease | _____ Gonorrhea | _____ Major surgery | _____ Psoriasis |
| _____ Alcohol addiction | _____ Depression | _____ Hay fever | _____ Malaria | _____ Rheumatic fever |
| _____ Allergies | _____ Diphtheria | _____ Hearing problems | _____ Measles | _____ Rheumatoid arthritis |
| _____ Alopecia | _____ Diverticulosis | _____ Hemorrhoids | _____ Mononucleosis | _____ Scarlet fever |
| _____ Anemia | _____ Drug addiction | _____ Hepatitis | _____ Multiple sclerosis | _____ Sciatica |
| _____ Attempted suicide | _____ Ear infections | _____ Hernia | _____ Mumps | _____ Skin ulcers |
| _____ Arteriosclerosis | _____ Eczema | _____ Herniated disc | _____ Myopia | _____ Skipped heart beats |
| _____ Back problems | _____ Emphysema | _____ Herpes | _____ Nervous breakdown | _____ Stroke |
| _____ Benign breast tumor | _____ Endometriosis | _____ High blood pressure | _____ Nervousness | _____ Syphilis |
| _____ Bleeding gums | _____ Excessive fatigue | _____ Hives | _____ Neuralgia | _____ Thyroid disease |
| _____ Bronchitis | _____ Eye disease | _____ Insomnia | _____ Night blindness | _____ Ulcerative colitis |
| _____ Candida albicans | _____ Fainting or dizzy spells | _____ Jaundice | _____ Numbness | _____ Vision problems |
| _____ Cataracts | _____ Gall stones | _____ Kidney stones | _____ Pancreatitis | _____ Other |
| _____ Chest pains | _____ Gastritis | _____ Liver disease | _____ Persistant cough | |