PALMER Chiropractic Clinics

San Jose Clinic

File # _____
Date: ___/___/___

Health Questionnaire

1 Patient Information

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nickname** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

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2 How Did You Hear About Us?

___A current intern. Please list the name of intern _____
___A current student. Please list the name of the current student _____
___A patient. Please list the patient so that we are able to properly thank the person_____
___A faculty member of Palmer West _____
___A staff member of Palmer West _____
___Yellow Pages ☐ Phone Book ☐ YP Online
___Internet. ☐ Google search ☐ Other, please specify:_____
___Drove by Palmer Campus.
___Advertisement. Please specify._____
___Sporting Event. Please specify._____
___I am a prospective student visiting the campus today.
___Facebook or other social media.
___Walk-in.
___VTA Light Rail.
___Palmer Alumni. Please specify._____
___Other. Please specify_____

3 Allergies

Are you allergic to any medication(s)?
❑ Yes ❑ No **If yes, which medications?**
_____

Are you allergic to any of the following?
❑ Bee Sting ❑ Latex ❑ Peanuts ❑ Shellfish
❑ Dairy ❑ Mold ❑ Pollen ❑ Wheat
❑ Eggs ❑ Nuts ❑ Other_____
Describe the reaction:_____

4 Smoking History

Do you currently smoke tobacco of any kind?
❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke:
❑ Current every day smoker
❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?
❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

5 Medications

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Medication Name	**Quantity / Dosage** (ie. 1 tablet / 5 mg)	**Frequency** (ie. 2 times / day)	**Start Date**
1				
2				
3				
4				
5				
6				

Do you currently use any recreational drugs? ❑ Yes ❑ No [ ] Check here if you take more than 6 medications

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6 Social History

WORK ACTIVITY: What is your job description: _____

What do you do most of the day at work? ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor ❑ Other:_____

What job did you do during most of your life? _____

How would you describe the physical stress level at work? ❑ Low ❑ Medium ❑ High

EDUCATION : Mark the highest level of education completed: ❑ Elementary school ❑ Middle school ❑ High School ❑ Vocational School ❑ GED ❑ Associates Degree ❑ Bachelors Degree ❑ Graduate Degree ❑ Doctorate ❑ other

DIET/NUTRITION:

Are you on any special diet? ❑ Yes ❑ No If yes, for what reason?_____

Is your weight a concern for you emotionally or physically? ❑ Yes ❑ No

Have you gained or lost over 10 pounds in the past 6 months without wanting to? ❑ Yes ❑ No

My dietary intake consists mainly of the following: (Mark all that apply)

❑ Fruits ❑ Vegetables ❑ Whole Grains ❑ High Fiber ❑ Low Fiber
❑ High Salt ❑ Low Salt ❑ High Sugar ❑ Low Sugar ❑ Low Carbohydrate
❑ High Fat ❑ Low Saturated Fats ❑ High Protein ❑ Low Calorie

Rate your appetite on the below scale of 1 to 10:

☺Normal Appetite 1 2 3 4 5 6 7 8 9 10 Eat Nothing☹

How many 8 ounce glasses of water do you drink a day? _____

Alcohol Use: Now? ❑ Yes ❑ No Amount/Weekly____ How long? _____ Years/Months

In the past? ❑ Yes ❑ No Amount/Weekly____ How long? _____ Years/Months

How many coffee caffeine drinks do you drink a day? Cups ____ None ____

How many soda caffeine drinks do you drink a day? Cans ____ None ____

Current Vitamins, Minerals, Herbs, etc. List ANY/ALL non-prescription items you are CURRENTLY taking.

	Vitamin, Mineral, Herbs	**Quantity / Dosage** (ie. 1 tablet / 5 mg)	**Frequency** (ie. 2 times / day)	**Start Date**
1				
2				
3				
4				
5				
6				

Health Review:

How many hours of sleep are you getting per night? ❑ Less than 5 ❑ 6-8 ❑ 8-10 ❑ 10 or more hours

How would you rate your sleep on the following scale? ☺Wake-up Fully Rested 0 1 2 3 4 5 6 7 8 9 10 No/Poor Sleep☹

How many days a week do you exercise for 30 minutes or more? ❑ 0 ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7

How would you rate the intensity of your exercise? ☺High Intensity 0 1 2 3 4 5 6 7 8 9 10 No Exercise☹

How would you rate your physical stress level? ☺No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed☹

How would you rate your emotional stress level? ☺No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed☹

List your major stressors: _____

What are you health goals? _____

In addition, talk to your doctor about other areas which may be affecting your health-such as worries about finances, social support, and alcohol, tobacco and/or drug use.

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Personal Health History

Are your currently under the care of a Healthcare Provider or any other doctor? ❑ Yes ❑ No
If yes, for what condition(s)_____
_____
Provider's Name _____ Phone Number_____
Has any doctor diagnosed you with Hypertension recently? ❑ Yes ❑ No
If yes, describe: _____
Has any doctor diagnosed you with Diabetes recently? ❑ Yes ❑ No
If yes, was your blood lab-work test for hemoglobin A1c >9.0% ❑ Yes ❑ No ❑ Not Sure
If yes, other comments regarding Diabetes: _____
Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Do you wear any of the following? ❑ Heel Lifts ❑ Innersoles ❑ Arch Supports ❑ Orthotics ❑ Other_____
For how long? _____ Were they prescribed by a doctor? ❑ Yes ❑ No
Have you seen a chiropractor in the past? ❑ Yes ❑ No Date of last visit_____
If yes, name and location of previous Chiropractor_____ Phone Number_____
Were you satisfied with your care? ❑ Yes ❑ No Why? _____

Date of last:				
	Chiropractic Exam		Prostate/PSA	
	Cholesterol		Mammogram	
	MRI		Pap Smear	
	CT-Scan		Colon	
	Spinal X-ray		Stool check for blood	

Childhood Illnesses:

❑ ADD
❑ atopic dermatitis
❑ allergies/hayfever
❑ anemia
❑ asthma
❑ bedwetting
❑ cerebral palsy
❑ chicken pox
❑ crohn's/colitis
❑ depression
❑ diabetes
❑ ear infections
❑ fetal drug exposure
❑ headaches
❑ hepatitis
❑ HIV
❑ measles
❑ mumps
❑ psoriasis
❑ rash
❑ scoliosis
❑ seizures
❑ sickle cell
❑ spina bifida
❑ other:

Immunization:

❑ All recommended vaccines ❑ Not vaccinated

❑ adenovirus
❑ haemophilus B
❑ influenza
❑ MMR(measles,mumps, rubella)
❑ pneumococcal
❑ tetanus
❑ other:_____
❑DTaP(diphtheria,tetanus,pertussis)
❑ hepatitis B
❑ IPV(polio)
❑ rotavirus
❑ varivax(chicken pox)

Adult Illnesses:

❑ ADD
❑ Alzheimer's
❑ arthritis
❑ asthma
❑ cancer
❑ cerebral palsy
❑ chicken pox
❑ colitis
❑ CRPS(RSD)
❑CVA(stroke)
❑ chicken pox
❑ cystic kidney disease
❑ depression
❑ diabetes
❑ eczema
❑ emphysema
❑ eye problems
❑ fibromyalgia
❑ heart disease
❑ hepatitis
❑ HIV
❑ high blood pressure
❑ influenza pneumonia
❑ liver disease
❑ lung disease
❑ lupus erythema
❑ multiple sclerosis
❑ Parkinson Disease
❑ unspecified pleural effusion
❑ pneumonia
❑ psoriasis
❑ psychiatric condition
❑ scoliosis
❑ seizures
❑ shingles
❑ STD's (unspecified)
❑ suicide attempt(s)
❑ thyroid problems
❑ vertigo
❑ Other:_____
_____

Injuries: (List date next to injury)

❑ back injury
❑ broken bones
❑ disability (ies)
❑ fall (severe)
❑ fracture
❑ head injury
❑ industrial accident
❑ joint injury
❑ laceration (severe)
❑ motor vehicle accident
❑ soft tissue injury
❑ Other:_____

Surgeries:

	Date	Procedure (e.g. knee repair)	Description	
1				In Patient/Out Patient
2				In Patient/Out Patient
3				In Patient/Out Patient
4				In Patient/Out Patient
5				In Patient/Out Patient

Review of Systems

Please indicate if you have any of the following by checking the box.

Constitutional	❑ None	❑ daytime drowsiness	❑ fever	❑ night sweats
	❑ chills	❑ fatigue	❑ loss of appetite	❑ weight gain / loss
Eyes/Vision	❑ None	❑ cataracts	❑ itching	❑ wears contacts/glasses
	❑ blindness	❑ double vision	❑ photophobia	
	❑ blind spots	❑ eye problems	❑ tearing	
Ears, Nose & Throat	❑ None	❑ fainting	❑ history of head injury	❑ runny nose
	❑ dizziness	❑ frequent sore throats	❑ loss of sense of smell	❑ sinus infection
	❑ ear discharge	❑ headaches	❑ nosebleeds	
	❑ ear pain	❑ hearing loss	❑ nasal congestion	
Respiration	❑ None	❑ cough	❑ shortness of breath	❑ wheezing
	❑ asthma	❑ coughing up blood	❑ sputum production	
Cardiovascular	❑ None	❑ high blood pressure	❑ paroxysmal nocturnal dyspnea	❑ varicose veins
	❑ claudication (leg pain and ache)	❑ low blood pressure	❑ shortness of breath with exertion	
	❑ heart problem	❑ orthopnea(difficulty breathing lying down)	❑ ulcers	
	❑ heart murmur	❑ palpitations		
Gastrointestinal	❑ None	❑ belching	❑ difficulty swallowing	❑ jaundice
	❑ abdominal pain	❑ black/tarry stool	❑ heartburn	❑ ulcers
	❑ abnormal stool (Color/consistency)	❑ constipation	❑ hemorrhoids	❑ rectal bleeding
		❑ diarrhea	❑ indigestion	
Female	❑ None/Not Applicable	❑ birth control	❑ frequent urination	❑ vaginal discharge
	❑ abnormal vaginal Bleeding	❑ breast lump/pain	❑ hormone therapy	
		❑ burning urination	❑ irregular menstruation	
		❑ cramps	❑ urine retention	
	I … ❑ am currently pregnant ❑ am NOT currently pregnant I … ❑ currently have menses ❑ currently DO NOT have menses My menses… ❑ are regular ❑ are NOT regular _____age of first menses _____age when menopause began Date of last menstrual period ____/____/____ If you have been pregnant in the past, please fill in the appropriate information below. _____Number of complicated pregnancies _____Number of uncomplicated pregnancies _____Number of C-sections _____Number of vaginal deliveries _____Number of miscarriages _____Number of terminated pregnancies Do you have any concerns about your sexual health? ❑ Yes ❑ No Are you or have you ever been a victim of domestic or sexual abuse? ❑ Yes ❑ No			
Male	❑ None/Not Applicable	❑ burning urination	❑ frequent urination	❑ prostate problems
		❑ erectile dysfunction	❑ hesitancy/dribbling	❑ urine retention
	Do you have any concerns about your sexual health? ❑ Yes ❑ No Are you or have you ever been a victim of domestic or sexual abuse? ❑ Yes ❑ No			

Endocrine	❑ None ❑ cold intolerance ❑ diabetes	❑ excessive appetite ❑ excessive hunger ❑ excessive thirst	❑ goiter ❑ hair loss ❑ heat intolerance	❑ unusual hair growth ❑ voice changes
Skin	❑ None ❑ change in nail texture	❑ change in skin color ❑ hair loss ❑ hives	❑ history of skin disorders ❑ itching ❑ numbness	❑ rash ❑ skin lesions/ulcers ❑ varicosities
Nervous System	❑ None ❑ dizziness ❑ facial weakness ❑ headache	❑ limb weakness ❑ loss of consciousness ❑ loss of memory ❑ numbness	❑ seizures ❑ sleeps disturbance ❑ slurred speech ❑ stress	❑ stroke ❑ unsteadiness of gait/loss of balance
Psychological	❑ None ❑ anxiety ❑ behavioral change	❑ bi-polar disorder ❑ confusion ❑ convulsions	❑ depression ❑ insomnia ❑ loss or change of appetite	❑ memory loss ❑ mood change
Hematologic	❑ None ❑ anemia	❑ bleeding ❑ blood clotting	❑ blood transfusion ❑ bruising easily	❑ fatigue ❑ lymph node swelling

8 Family History

Relation	**Age** (now or at death)			**Serious illness/cause of death**
Father		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Paternal grandfather		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Paternal grandmother		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Mother		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Maternal grandfather		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Maternal grandmother		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Brother(s)		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Sister(s)		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Son(s)		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	
Daughter(s)		❑ alive ❑ deceased	❑ no significant disease ❑ has/had_____	

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9 Patient Condition

Reason(s) for visit:_____

Is this condition due to an accident? ❑ Yes ❑ No ❑ Auto ❑ Work ❑ Home ❑ Other Date_____

What was the mechanism of accident/injury?_____

When did your symptoms appear?_____ Is this condition getting worse? ❑ Yes ❑ No

How often do you have this problem? _____ Is it constant or does it come and go?_____

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are difficult / painful to perform:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Circle your pain on the below scale of 0 to 10:

(at rest) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

(with activity) ☺ No Pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

What treatment have you already received for your condition?

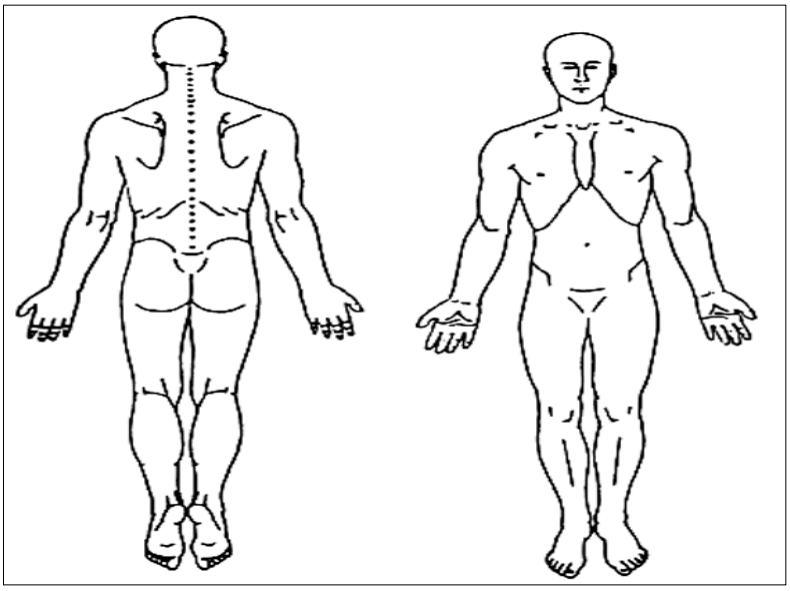
❑ Medications ❑ Surgery ❑ None ❑ Physical Therapy ❑ Chiropractic Care

Name of other doctor(s) who have treated you for this condition_____

_____

Were you satisfied with the results of your treatment? ❑ Yes ❑ No Explain_____

Mark an "X" on the picture where you continue to have pain, numbness or tingling.



While we will work closely with you to resolve your chief complaint, as health professionals we are also concerned about your overall wellness. On future visits we will discuss issues with you that may impact your overall health.

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at the Palmer Clinics at this time.

Patient Signature Date

Signature of Parent or Legal Guardian Relationship