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

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