Dr Patrick Hamel, DC, Chiropractor Dr Ingrid Hamel, DC, Chiropractor

HEALTH QUESTIONNAIRE

Personal Information

Full name_____ Date _____

Address_____ City _____ Postal code _____

Telephone: Home: _____ Work: _____

Cell: _____ E-mail: _____

Date of birth: _____ Age: _____ Gender: Male/Female _____

Occupation:_____ Employer: _____

Who were you referred by: _____

Primary concern

What brings you to this clinic? _____

Date when concern began:_____ Date of most recent episode _____

Was there an event that created the condition?_____

Have you had this or similar conditions in the past?_____

What makes it better ?_____ Worse?_____

Is the condition getting worse?_____

Is the condition worse at a certain time of day?_____

Does it interfere with: Work?_____ Sleep?_____ Activity ? _____ Other? _____

Please list your goals and expectations for treatment, (immediate and future):

_____

_____

I am also concerned with optimizing my overall health and well-being: _____

Health History

List other current health issues and problems: _____

_____

List other health care practitioners seen, treatments given and results obtained:

_____

_____

_____

List any surgeries (including the dates and results) you have had:

_____

_____

_____

Have you ever been in an accident or seriously injured? If so, please describe _____

_____

_____

Dental or TMJ (jaw) problems? _____ Do you grind your teeth at night? _____

Have you had your wisdom teeth removed? _____ Root canal? _____

List all medications, supplements or remedies you are currently taking: _____

_____

_____

Are you allergic to any medications? _____

Food intolerances or allergies? _____

Family History

List age and health problems (if any) for family members:

Father _____ Mother _____

Children _____ Siblings _____

Grandparents _____

General

Describe your use of: Cigarettes _____ Alcohol _____ Drugs _____

How often do you exercise? _____ Types: _____

How many hours of sleep per night do you get ? _____ Do you fall right to sleep ? _____

Do you wake during the night? _____ Do you wake up feeling rested ?_____

Pain Questionnaire (if relevant)

Place a vertical line through the pain scale below at the point that best describes your pain

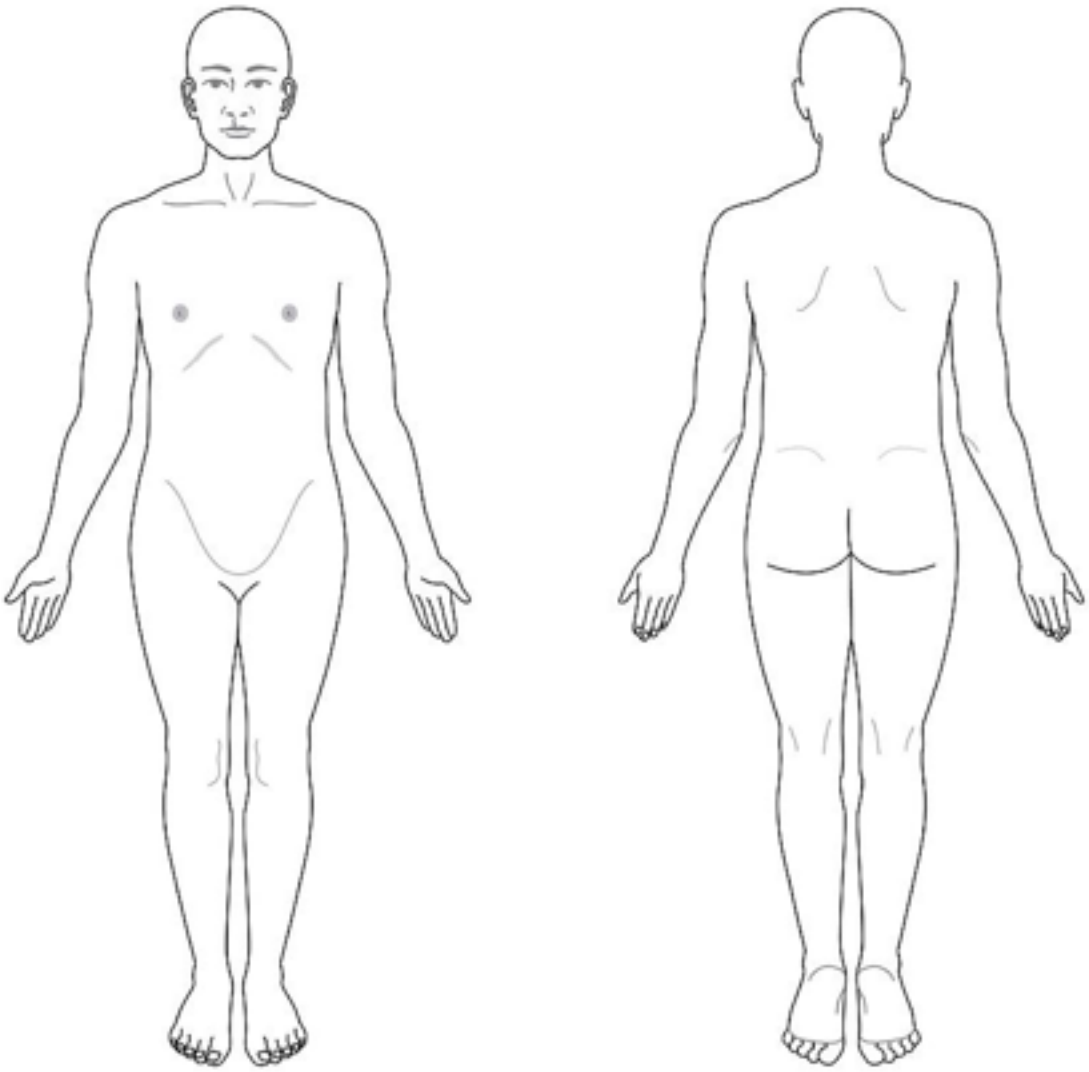
(0 = no pain, 10 = worst pain imaginable)

0——————1——————2——————3——————4——————5——————6——————-7——————-8——————-9——————-10

Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

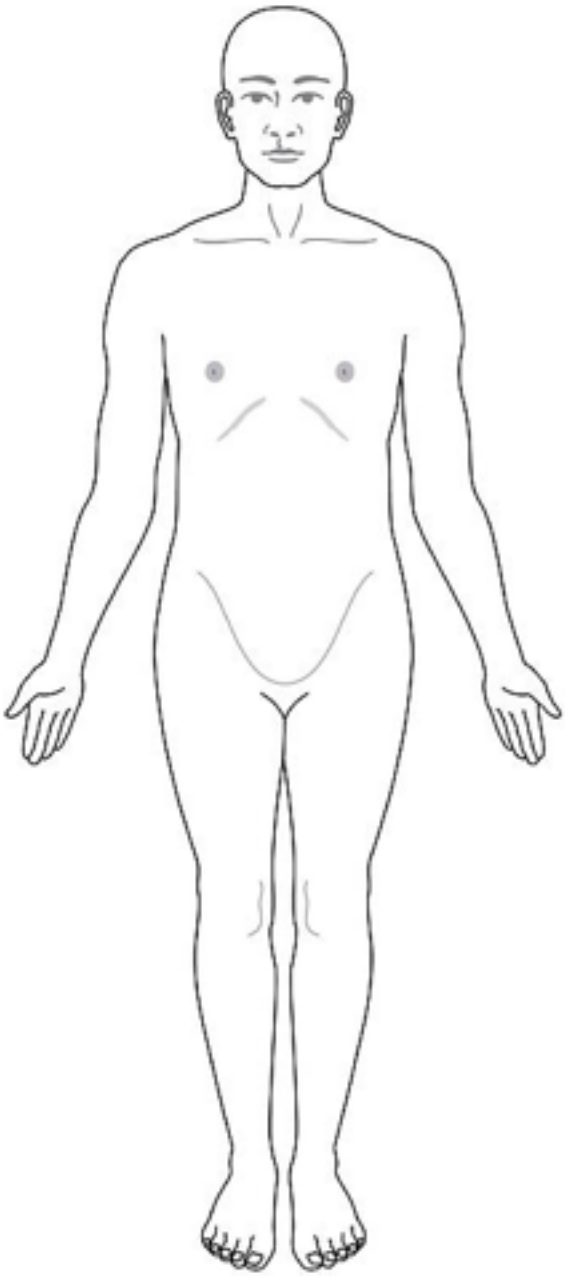
A = Ache B = Burning N= Numbness O = Other

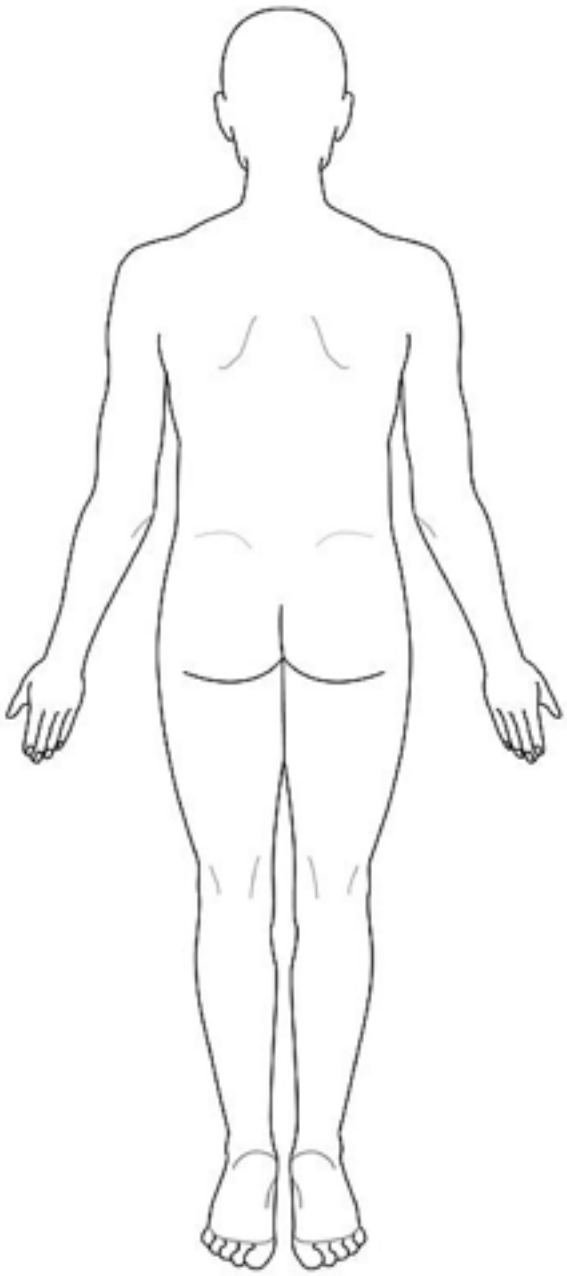
P = Pins & Needles S = Stabbing T = Throbbing



History of Injury

Please mark with an *X* all the places on your body which have ever been injured (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises. falls, etc.). Please also include any tattoos and piercings, other than ear.





SYMPTOM SURVEY

CIRCLE the symptom if you are currently experiencing it or if it is a common occurrence.
UNDERLINE the symptom if it is not a problem now, but was a problem in the past (over 3 months ago)

GENERAL

Low energy/fatigue

Weakness

Fever

Headaches

Lack of sleep

Reduced mental acuity

SKIN

Dry skin

Itching

Varicose veins

Cold sores/fever blisters/canker sores

Boils

Hives

Rashes

Sores

Eczema

Change in your skin/nails

EYES

Cataracts/glaucoma

Eye pain

Double vision

Far or near sighted

Flashing lights

Spots, specks or floaters

NECK

Goiter

Lumps

Pain/stiffness

Swollen glands

RESPIRATORY

Asthma

Bronchitis

Cough

Pneumonia

Tend to hold breath

Wheezing

Mucous/sputum

Trouble breathing w/exercise

CARDIAC / VASCULAR

Arrhythmia

Chest pain

Heart trouble

Heart murmur

High or Low blood pressure

Palpitations/racing/pounding

Shortness of breath

Swollen feet/ankles/lower legs

Blood clots

Poor circulation

EARS

Ear discharge/excessive wax

Earaches or infections

Hearing loss

Ringing/tinnitus

Vertigo/dizziness

NOSE/SINUS

Sinus congestion

Frequent colds/infections

Nosebleeds

MOUTH/THROAT

Bleeding gums

Dentures

Tooth decay

Frequent sore throats

Grind teeth at night

Hoarse voice/frequent loss of voice

NEUROLOGIC

Blackouts

Fainting

Numbness

Paralysis

Dizziness

Tremors

Seizures

Difficult to concentrate/focus

Loss of equilibrium

Muscle weakness

GASTROINTESTINAL

Belching/burping

Flatulence/gas

Black or tarry stools

Blood in stool

Change in stool

Colitis

Constipation

Diarrhea

Excessive hunger

Heartburn

Food intolerances

Hemorrhoids

Indigestion

Nausea

Poor appetite

Stomach pain

Trouble swallowing

Vomiting

ENDOCRINE

Diabetes

Excessive thirst or hunger

Excessive sweating

Lack of sweating

Heat or cold intolerance

Thyroid problems

Hair loss

Dizzy when standing or rising quickly

Excessive weight loss

Excessive weight gain

MUSCLES & JOINTS

Arthritis

Bursitis/Tendonitis

Gout

Poor posture

Chronic pain

Pain with specific movement(s)

Pain relieved by anti-inflammatory meds

Pain/tenderness/numbness in neck

Pain/tenderness/numbness in shoulders

Pain/tenderness/numbness in arms/elbows

Pain/tenderness/numbness in wrists/hands

Pain/tenderness/numbness in upper/lower back

Pain/tenderness/numbness in hips

Pain/tenderness/numbness in knees

Pain/tenderness/numbness in feet/ankles

HORMONAL FEMALES

Age at first period _____ Age at menopause _____

Number of days in cycle _____ Length of period _____

Bleeding between periods

Yeast infections/Bladder infections

Sexually transmitted disease/infections

Abnormal discharge/itching/sores

PMS (circle): Fatigue Cramping Bloating

PMS (circle): Breast tenderness Back pain Other

Birth control method: _____

Pain with intercourse

Decreased libido

Number of pregnancies _____

Number of deliveries _____ Caesarean? _____

PSYCHOLOGICAL

Anxiety

Depression

Insomnia/difficulty falling asleep

Nervousness

Poor memory/forget quickly

Violent thoughts

Suicidal ideas

Tend to worry

HEMATOLOGIC

Anemia

Bruise easily

URINARY

Frequent urination

Blood in urine

Incontinence

Painful urination

Urinate more than once per night

Difficulty emptying bladder

HORMONAL MALES

Prostate problems

Itching/rash/discharge

Hernia

Premature ejaculation

Sexually transmitted disease/infect.

Testicular lump/pain

Vasectomy

DIET HISTORY

How much do you drink each day(8oz/225ml): Water:___ Juice:__ Soda diet:__ Soda regular ___

Coffee: Regular:___Decaf:___ Tea: Regular:___ Herbal tea:___ Energy Drinks/Other:_____

List oils or fats that you use in cooking:_____

Do you frequently skip meals? _____ Are you on any special diet or nutrition program? _____

Describe:_____

Are you allergic or sensitive to any foods? _____ If yes, name the foods and describe the problem: _____

What foods do you dislike?_____ What are your favorite foods?_____

Circle the foods you crave:

Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods

Spicy foods Sour foods Cereals Dairy Other _____

*Do you use: (circle) Butter Margarine Shortening Coconut oil Other _____

*Do you eat organic foods? Yes No _____

*Do you know what partially hydrogenated fats are? _____ If yes, do you eat them? _____

*Do you eat from fast food restaurants? _____ If yes, how often? _____

What do you usually eat for **breakfast**?_____

What do you usually eat for **lunch**?_____

What do you usually eat for **dinner?**_____

What do you usually eat for **snacks** (in between meals and/or before bed)?_____

What foods do you eat often (at least once a day, every day)?_____

How many bowel movements do you have per day?_____ Difficult ? _____

Type of sport/activity/exercise routine you participate in:_____

What frequency do you exercise each week? _____

Do you wear orthotics/arch supports/or any other devices during the day or when you exercise?

_____

I declare to have answered honestly and to the best of my knowledge this document which describes the general state of my health.

Name _____ Signature _____