PARKVIEW
Health & Wellness Center

New/Returning Patient Questionnaire

Please take your time to complete this form legibly and thoroughly. The more detailed you are, the more we will be able to help you achieve your health goals.

Name: _____ Date: _____

Male: _____ Female:_____ Height: _____ Weight: _____ Date of Birth: _____

__Married __Single __Widowed __Divorced __Partnered Children (Ages): _____

Address: _____City: _____ Zip: _____

Drivers License Number: _____

Is your visit today as a result of a work injury or auto accident? *Please Circle*: Yes or No

Mobile: _____Home phone: _____ Bus. Phone: _____

Employer:_____Address:_____

Emergency Contact: Name: _____ Phone #: (_____)_____
Relationship to Patient: _____

How were you referred to us? _____

Please choose one for patient related information:
(appointment reminders, billing, etc.)

1. Regular mail
2. Phone Call or Voicemail
3. Text Message – Cell # _____ initial: _____
4. Email

Please Print Clearly
Email Address: _____

What are the symptoms or problem that you want us to help you with? Please list:

Have you had chiropractic care or acupuncture before? ___Acupuncture ___Chiropractic ___Both
Please explain the results:

Your Pain
Is your health problem a work-related injury? ___Yes ___No If "yes" did you report the injury? ___Yes ___No
In what position do you sleep? ___side ___back ___front Do you use a pillow? ___Yes ___No
Did your pain or symptoms come on: ___gradually ___suddenly Is it: ___constant ___intermittent
What time of the day is the pain the worst: ___morning ___afternoon ___evening ___night ___constantly

Initial _____

What makes your pain symptoms worse?

What makes your pain symptoms better?
Please circle those you presently (in recent weeks) have. Underline those you have had in the past.

General
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Imbalance
Seizures
Epilepsy
Sleeping difficulties
Sleep apnea
Quality of sleep
Sleep ___ hrs/night
Feel run-down
Fatigue
Hypoglycemia
Nervousness/anxiety
Panic attacks/phobias
Depression
Mental disorder(s)
Alcohol problem
Drug problems(s)
Diabetes
Neuralgia
Anemia
Cancer
Memory Loss
Scarlet Fever
Typhoid Fever
Rheumatic Fever
Measles
Mumps
Chicken Pox
Weight loss___lbs
Weight gain___lbs
Other_____

Ear, Nose & Throat
Eye strain/pain
Failing vision
Blurred vision
Glaucoma
Sensitivity to light
Hearing problems
Ear noises
Ear discharge
Sinus infection
Nose bleeds
Nasal obstruction/ drainage
Sore throat
Hoarseness
Loss of Voice
Dental decay
Mouth sores
Gum disease
Teeth grinding
Jaw Pain
Frequent colds
Thyroid condition
Tonsillitis
Enlarged glands
Hay Fever
Other_____

Skin
Rashes
Skin eruptions
Eczema
Itching
Bruise easily
Dry skin
Boils
Moles
Varicose veins
Sensitive Skin
Hair loss
Other_____

Respiratory
Asthma
Pneumonia
Emphysema
Tuberculosis
Bronchitis
Pleurisy
Chronic cough
Spitting phlegm
Spitting blood
Chest Pain
Difficult breathing
Shortness of breath
Other _____

Cardiovascular
Rapid heartbeat
Slow heartbeat
Irregular heartbeat
High blood pressure
Blood clots
Low blood pressure
Pain over heart
Pacemaker
Hardening of arteries
Swelling of ankles
Poor circulation
Stroke/TLA
Other_____

Muscle & Joint
Stiff neck
Backache
Gout
Swollen Joints
Painful Joints
Arthritis
Bursitis
Tendinitis
Muscle or joint weakness
Muscle spasms or cramps
Fibromyalgia
Foot trouble
Spinal curvature
Osteoporosis
Other _____

Genitourinary
Frequent urination
Night urination __times
Painful urination
Blood in urine
Pus in urine
Kidney infection or stones
Bed-wetting
Inability to control urine
Prostate trouble
Hernia
Sexually transmitted disease
Sexual dysfunction/ difficulty
Other _____

Gastrointestinal
Trouble swallowing
Bad breath
Indigestion/ heartburn
Nausea
Poor appetite
Belching or passing gas
Excessive hunger
Cravings
Eating Disorder
Vomiting of blood
Ulcers
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colitis
Appendicitis
Bowel Condition
What aggravates the above?
_____
Hemorrhoids (piles)
Intestinal worms
Parasites
Hepatitis
Liver trouble
Gall Bladder trouble
Jaundice
Bad body odor
Other _____

For Women Only
PMS (list symptoms)
_____
Mood swings/ irritability
Painful menstrual period
Excessive flow
Bleeding between cycles
Irregular cycle
Cramps or backache w/period
Endometriosis
Ovarian cysts

Initial _____

Uterine Fibroids	Breast pain/	Menopausal	Other _____
Abnormal PAP results	tenderness	Symptoms	
Vaginal Discharge	Breast Lumps	Hot Flashes	

List surgical procedures or hospitalizations with dates: _____

_____

Accidents, with or without injury (car accident, slips, etc): _____
X-ray, MRI, CAT or bone scans (where, when and what was found?): _____

_____

What do you typically eat for:

Breakfast: _____ Time: _____

Lunch: _____ Time: _____

Dinner: _____ Time: _____

Snacks: _____ Time: _____

Drink (with or between meals) _____

How many times a day do you have bowel movements: _____
Are your bowel movements: ____loose ____hard ____difficult to pass ____strong-smelling
____accompanied by gas
What is the typical color: ____blackish ____brown ____clay ____greenish ____bloody

For those that apply to you, please list indicated quantities consumed:
Smoke Cigarettes (# per day) _____ Other tobacco (amnt per day) _____
Wine/Beer (# of glasses per day or week) _____ Hard liquor (oz. per day or week) _____oz.
Coffee (# of cups per day) _____ Tea (# of cups per day) _____
Soda (# of cups/cans per day) _____caffeinated _____non-caffeinated _____diet
Sweets (candy, chocolate per week) _____oz.
Water (# of cups per day) _____chlorinated _____bottled ____filtered

What allergies to foods, drugs or inhalants do you have and how do you react?

Typically how often do you exercise per week? ____ never ____once/twice _____daily

Your Current Mental Health
On a scale of 0-10 (10 highest), what number do you believe reflects your current level of stress? _____
Please list the four most significant stress events in your life.
Initial _____

1.) _____ 2.) _____

3.) _____ 4.) _____

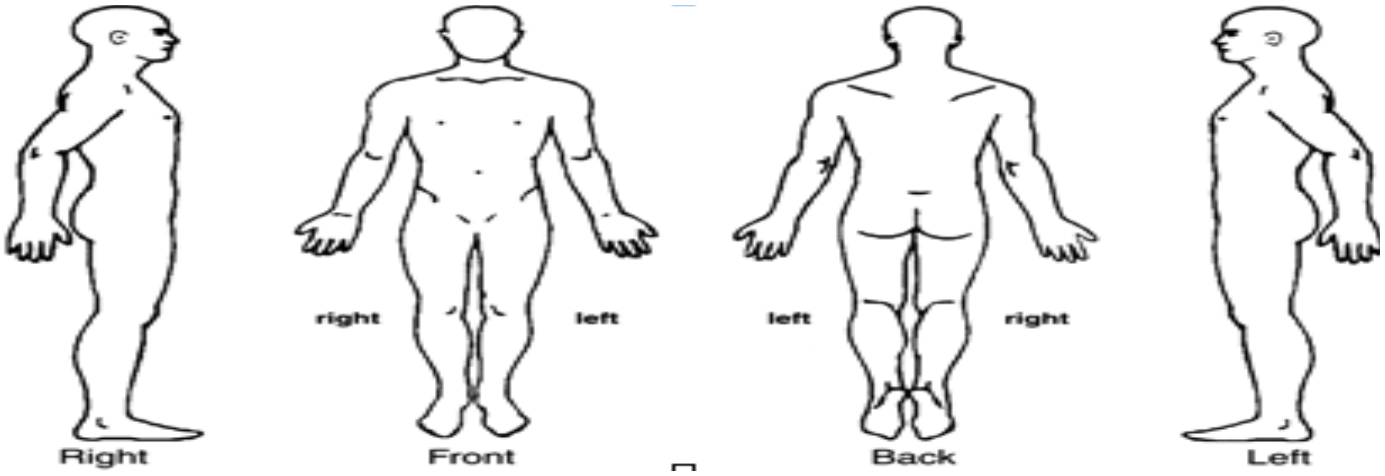
Patient Pain Drawing

Please place the symbol(s) on the body in the area(s) that best describe(s) the pain or discomfort you are having:

SP= Sharp Pain DP= Dull Pain B=Burning N=Numbness T=Tingling
S=Stabbing A=Ache TH=Throbbing

On a scale of 0 – 10 (0= pain free, 10= constant pain), rate each area of pain:

Neck _____ Mid back _____ Low back_____ Shooting pain_____ Numbness_____ Other_____



In which of the following areas would you like our support? (Check all that apply, circle the ones that's most important)

____ Have more energy

____ Be happier

____ Monitor my body's aging

____ Be less tired after lunch

____ Not need so many drugs

____ Be stronger

____ Get rid of allergies

____ Be more flexible

____ Reduce my risk of degenerative disease

__ __Improve my skin quality

____ Slow accelerated aging

____ Sleep better

____ Be less depressed

____ Maintain a healthier life longer

____ Get less colds/flu

____ Be less moody

____ Reduce body fat

Initial _____

____ Improve my memory

____ Have more sex drive

____ Learn how to reduce stress

Please list any and all drugs/medications (over –the-counter/prescription), which you are presently taking or have taken. When did you start/stop their use? Dosage?

What supplements, vitamins and/or herbs do you take?

Medical History
Is there a history of the following conditions in your family:

____ Heart disease

____ High blood pressure

____ Circulatory conditions

____ Cancer

____ Diabetes

____ Osteoarthritis

____ Rheumatoid arthritis

____ Multiple sclerosis

____ Muscular dystrophy

____ Mental illness

____ Autoimmune disorders

____ Asthma

____ Allergies

____ Psoriasis

____ Eczema

____ Alcoholism

____ Drug Abuse

Any other conditions that are pertinent to your present state of health? _____

_____

This questionnaire is strictly confidential between you and the Park View Health & Wellness Center professional. Please go back over your responses and consider their accuracy. Thank you!

I authorize the Park View Health & Wellness Center's practitioners and staff to perform examinations and treatment deemed necessary by my provider for my condition.

Signature _____ Date _____

Guardian's Signature _____ Date _____

Initial _____