Outten Chiropractic
401 High House Rd., Suite 110
Cary, NC 27513
(919) 467-3362 – FAX: (919) 467-3233

Date: _____

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete this form as accurately as possible. Your answers will help us to determine whether chiropractic can help you. If you do not sincerely believe your condition can respond satisfactorily, we will not accept your case.
Thank you for your cooperation.

PERSONAL INFORMATION:

Full Name:_____ Age:_____ Birthday: _____
Address: _____ City:_____ State:_____ Zip:_____
Telephone # (Home):_____(Work):_____(Cell)_____ _____Social Security #: _____
___ Male ___ Female (Marital Status) M S W D Spouse's Name: _____
# of Children: _____ Name(s): _____
E-Mail Address:_____
Occupation:_____ Employer:_____ Referred By:_____
By what name would you like to be addressed in our office: _____
Do you have Insurance? ___ Yes ___ No Company:_____
Person responsible for payment or bill: _____

MEDICAL INFORMATION:

Primary Care Physician:_____ Address:_____
Date of Last: Physical Exam:_____ Blood Pressure Check:_____ X-rays:_____
Medication(s) taken at present time: _____
List surgical operations & dates: _____
Is there any illness in your family? ___YES ___NO *If yes, give relation and illness*:_____
How would you grade your general stress level? ___ No Stress ___Minimal Stress ___Moderate ___Greatly Stressed
Physical activity at work: ___ Sedentary more than 50% of workday ___Light Manual ___Manual Labor ___Heavy Manual
General Physical Activity: ___ No regular exercise program ___Light exercise program ___Strenuous exercise program
At work do you do more: Sitting___ Standing___ No issue____

CURRENT COMPLAINTS:

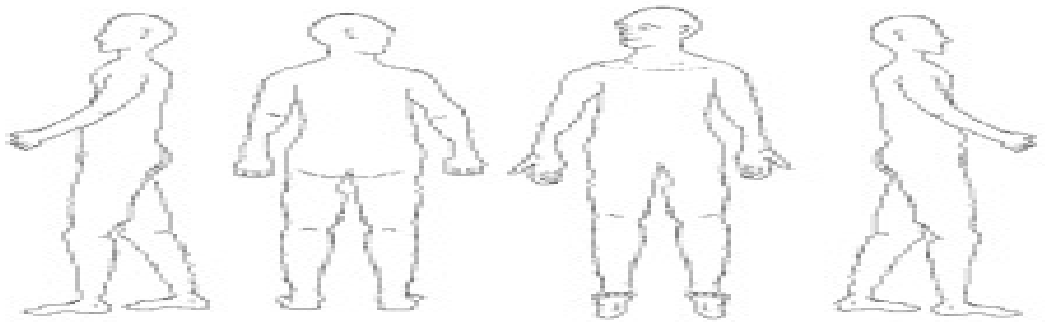
Purpose of this appointment? _____
Present Complaint:_____
When did your problem begin? *(Specific date if possible)* _____
Describe how your problem began:_____
Please describe the character of your current pain *(You may check one or more):*
___Stabbing ___Sharp/Dull ___Aches/Sore ___Throbbing ___Numbness ___Burning ___Tingling ___Other:_____
Is the pain: ___Constant (76-100%) ___Frequent (51-75%) ___Occasional (26-50%) ___Intermittent (25% or less)
How bad is your pain or ache? Please circle a number: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)
What makes it better?__Nothing ___Lying Down ___Walking ___Standing ___Exercise ___Inactivity ___ Other:_____
What makes it worse?__Nothing ___Lying Down ___Walking ___Standing ___Exercise ___Inactivity ___ Other:_____
Other doctors consulted for this condition?:_____
Treatment given: ___Surgery ___Spinal Injections ___PT ___A Back Support ___Medication:_____
___ Spinal Adjustment ___ Other:_____ If none check here:_____
Have you had similar complaints in the past?: ___Yes ___No *If yes type of treatment received*:_____
Any prior auto, work or other accident? Give dates and details: _____
_____

(Continue on back)

Are your complaints affecting your ability to work or otherwise be active?

___ No effect
___ Some physical restrictions (able to perform light duty tasks)
___ Need limited assistance with common everyday tasks
___ Need assistance often
___ Have a significant inability to function w/o assistant
___ I am totally disabled (impaired)

SYMPTOM LOCALIZATION:



SIGNIFICANT PROBLEMS:

GENERAL
___ ALLERGY
___ DIZZINESS
___ EAR PROBLEMS
___ FATIGUE
___ FREQUENT COLDS
___ HEADACHES
___ NOSE BLEED
___ NUMBNESS
___ SINUS INFECTION
___ SORE THROAT
___ SUDDEN WEIGHT LOSS OR GAIN
___ TONSILLITIS

GENITO-URINARY
___ FREQUENT URINATION
___ INABILITY TO CONTROL URINE
___ KIDNEY INFECTION OR STONES
___ PAINFUL URINATION
___ PROSTATE TROUBLE

CARDIO-VASCULAR
___ HIGH BLOOD PRESSURE
___ HEART CONDITION
___ SWELLING OF ANKLES

GASTROINTESTINAL
___ CONSTIPATION
___ DIARRHEA
___ GALL BLADDER TROUBLE
___ INTESTINAL TROUBLE
___ NAUSEA & VOMITING
___ STOMACH PROBLEMS

RESPIRATORY
___ CHEST PAIN
___ CHRONIC COUGH
___ DIFFICULT BREATHING

MUSCLE & JOINT
___ ANKLE PAIN
___ ARM PAIN
___ ELBOW PAIN
___ FOOT TROUBLE OR PAIN
___ KNEE PAIN
___ LEG PAIN
___ NECK PAIN
___ PAIN BETWEEN SHOULDERS
___ PAINFUL LOW BACK
___ RIB PAIN
___ SWOLLEN JOINTS

HAVE YOU HAD ANY OF THE FOLLOWING?
___ AIDS
___ ALCOHOLISM
___ ANEMIA
___ ARTHRITIS
___ CANCER
___ DIABETES
___ HEART DISEASE
___ MENTAL DISORDERS
___ NERVOUS BREAKDOWN
___ POLIO
___ RHEUMATIC FEVER

FOR WOMEN ONLY
___ HOT FLASHES
___ IRREGULAR CYCLE
___ LUMPS IN BREAST
___ PAINFUL MENSTRUATION

HABITS
___ COFFEE
___ TEA
___ TOBACCO
___ ALCOHOL
___ EXCESSIVE SLEEP (OVER 8 HRS)

To the best of my knowledge the preceding answers to the questions on this form are the complete truth regarding my health history.

Print Name:_____ Sign:_____ Date:_____

Patient or Guardian