

Chiropractic Health Questionnaire

Patient Name _____ Date _____

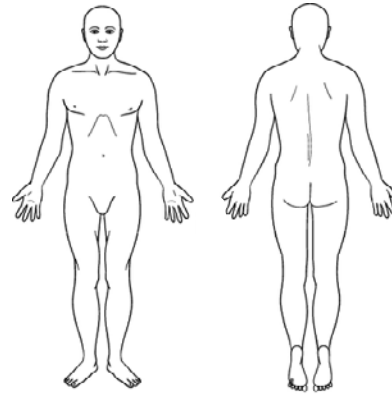
1) When did your symptoms start? _____

Describe your symptoms and how they began _____

2) How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3) What describes the nature of your symptoms?

- Sharp
- Dull Ache
- Numb
- Shooting
- Burning
- Tingling

4) How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

5) During the past 4 weeks:

Indicate the average intensity of your symptoms None 1 2 3 4 5 6 7 8 9 10 Unbearable

How much has the pain interfered with your normal work? (Including both work outside the home and house work)

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

How much of the time has your condition interfered with your social activities? (Like visiting with friends, relatives, etc.)

- Most of the time
- Some of the time
- A little of the time
- Not at all

6) In general, would you say your overall health right now is... Excellent Very Good Good Fair Poor

Who have you seen for your symptoms?

- No One
- Other Chiropractor
- Medical Doctor
- Physical Therapist
- Other

7) Have you had similar symptoms in the past? Yes No

If you have received treatment in the past for the same or similar symptoms, who did you see?

- This Office
- Other Chiropractor
- Medical Doctor
- Physical Therapist
- Other

What tests have you had for your symptoms and when were they performed?

- Xrays: Date _____
- MRI: Date _____
- CT Scan: Date _____
- Other: Date _____

8) What is your occupation?

- Professional/Executive
- Tradesperson
- Homemaker
- Retired
- White Collar / Secretarial
- Laborer
- Full Time Student
- Other

If you are not retired, a homemaker, or a student, what is your current work status?

- Full-time
- Part-time
- Self-employed
- Unemployed
- Off work
- Other

Patent Signature _____ Date _____

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