BRUCE COUNTY CHIROPRACTIC & REHABILITATION CENTER

Pt#_____

Health Status Survey

Patient Name: _____ Date: _____

Please check V in the box for those conditions or symptoms that you have had in the past. Please X the box for any conditions or symptoms presently causing you problems.

General Symptoms

___ Loss of consciousness
___ Blackouts
___Headache
___Migraine
___Fever
___Excess Sweating
___Night Sweats
___Loss of weight
___Night Pain
___Generalized Pain
___Nervousness
___Convulsions
___Loss of Sleep
___Mental illness

Neurologic

___Dizziness
___Fainting
__Problem Speaking
__Problem Swallowing
___Blurred Vision
___Double Vision
___Nausea
___Clumsiness
__Numbness or Tingling
Seizures

Respiratory

___Asthma
___Chronic Cough
___Spitting up phlegm
___Spitting up blood
___Difficulty breathing
___Bronchitis
___Emphysema

Muscle and Joints

___Sore/Stiff Neck
___Mid back ache
___Low back ache
___Painful Tailbone
___Shoulder Pain
___Arm/forearm pain
___Elbow pain
___Wrist/hand pain
___Hip pain
___Knee pain
___Ankle/foot trouble
___Arthritis
___Loss of strength
___Osteoporosis

Internal pins, wires, or artificial joints?

_____
_____
_____

Eyes/Ears/Nose/Throat

___Failing Vision
___Eye Pain
___Failing Hearing
___Earache
___Ring/ buzz in ears
___Frequent Colds
___Sinus Infection
___Enlarged Thyroid
___Enlarged Glands

Skin Conditions

___Rashes/ Itchy
___Bruise easy
___Dryness
___Boils
___Hives (allergies)
___Infectious skin condition

Medications:

Cardiovascular

___Bleeding Disorder
___High blood Pressure
___Low Blood Pressure
___Chest pain
___Chronic Congestive
___Heart Failure
___Stroke
___Hardening of arteries
___Varicose Veins
___Swelling of ankles
___Poor circulations
___Heart/blood disease
___Angina
___Pacemaker
___Haemophilia

Genitourinary

___Trouble urinating
___Blood in urine
___Kidney infection
___Bedwetting
___Prostate trouble

GU for Women

___Painful menstruation
___Excessive flow
___Hot Flashes
___Irregular/absent cycle
___Cramping/backache
___Vaginal discharge
___Swollen breast
___Lump in breast

Currently on birth control pills/patch?
Yes No
Previously on birth control pills/patch?
Yes No
# of pregnancies_____
# of children_____
Currently Pregnant ___

Gastrointestinal

___Poor appetite
___Indigestion
___Excess Hunger
___Belching/Gas
___Vomiting
___Pain over stomach
___Constipation
___Diarrhea
___Haemorrhoids
___Jaundice
___Gall bladder
___Intestinal worms
___Ulcer
___Diabetes

Allergies or hypersensitivities:

Do you currently smoke?
Yes No If yes, How much?
Previously smoke?
If yes, How much?

Have you ever been hospitalized? why/when?

Have you ever been diagnosed with

Cancer_____
HIV/Aids_____
Hep A/B/C_____
Herpes_____

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Symptom Diagram

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include ALL areas. Use the symbols provided below.

Symbols:

Numbness = = = = Pins and Needles o o o o Burning x x x x

Stabbing & Sharp ~ ~ ~ ~ Dull & Aching △ △ △ △ Stiff & Tight 2 2 2 2

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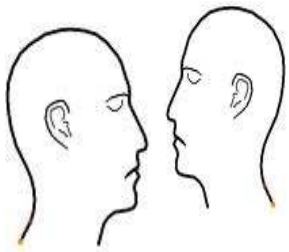
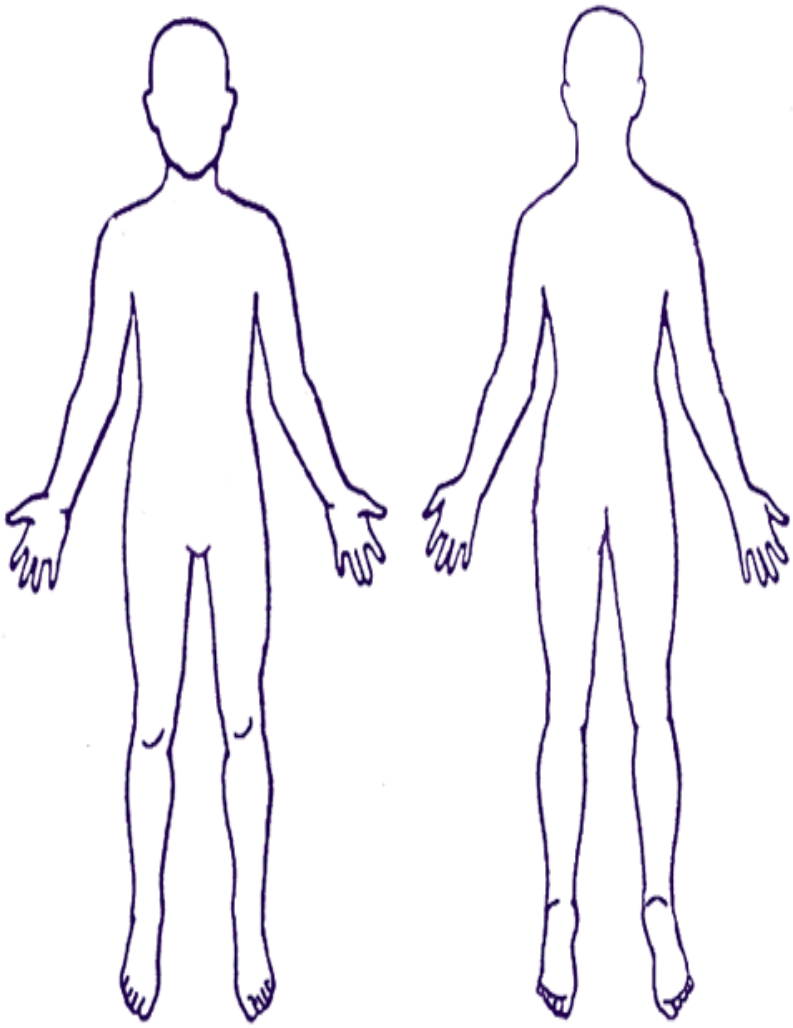
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