Ultimate Health Chiropractic

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Health status Survey

Last Name : …… **Date (D/M/Y):** …… /…… / 20….

First name : …… **Age:** …….. **File Number:** …….

Please check (X) : for **present** symptoms and conditions
Please check (√) : for symptoms and conditions **in the past**

General Symptoms	**Respiratory**	**Skin**
Loss of consciousness	Asthma	Rashes/itching
Blackouts	Chronic cough	Bruise easy
Headache	Spitting up phlegm	Dryness
Fever	Spitting up blood	Boils
Excess sweating	Difficulty breathing	Hives (allergies)
Night sweats	**Cardiovascular**	**Gastrointestinal**
Loss of weight	Bleeding disorder	Poor appetite
Night pain	High blood pressure	Indigestion
Generalized pain	Chest pain	Excess hunger
Nervousness	Stroke	Belching or gas
Convulsions	Hardening of arteries	Vomiting
Loss of sleep	Varicose veins	Pain over stomach
Neurologic	Swelling of ankles	Constipation
Dizziness	Poor circulation	Diarrhea
Fainting	Heart/blood disease	Hemorrhoids (piles)
Problem speaking	Angina	Jaundice
Problem swallowing	**Genitourinary**	Gall bladder trouble
Blurred vision	Trouble urinating	Intestinal worms
Double vision	Blood in urine	Gastric Ulcer
Nausea	Kidney infection	Diabetes
Clumsiness	Bedwetting	Have you ever had any fractures? yes ☐ No ☐ if yes, where ?
Numbness or tingling	Prostate trouble	
Muscles and Joints	**GU for Women**	
Sore/stiff neck	Painful menstruation	Have you ever been in a car accident? yes ☐ No ☐ if yes, when ?
Mid back ache	Excessive flow	
Low back ache	Hot flashes	
Painful tailbone	Irregular/absent cycle	
Shoulder pain	Cramping/backache	Have you ever been hospitalized? yes ☐ No ☐ why/when ?
Arm/forearm pain	Vaginal discharge	
Elbow pain	Swollen breasts	
Wrist/hand pain	Lump in breasts	
Hip pain	Number of Pregnancies ☐ Kids ☐	Are you currently a smoker? yes ☐No☐ How much? …… /d
Loss of strength		
Knee pain		Did you smoke previously? yes ☐No☐How much? …… /d
Ankle/foot trouble		
Arthritis	**Have you ever been diagnosed with ;**	
Eyes/Ears/Nose/Throat		
Failing vision	Cancer? …….. yes ☐ No ☐ What type ? ……..……..	
Eye pain	HIV/AIDS?..... yes ☐ No ☐ When ? ……..……	
Red eye	Hepatitis A/B/C?..... yes ☐ No ☐ What type and when ?.....	
Failing hearing	**Medications** (list):	
Earache	- Currently on birth control pills/patch? Yes ☐ No ☐	
Enlarged glands	- Previously on birth control pills/patch? Yes ☐ No ☐	
Ring/buzz in ears	- Other Medications :	
Frequent colds	- ……	
Sinus infection	- ……	