Chemainus
Chiropractic Clinic

# Health Status Survey

Patient Name: _____ File #: _____ Date: _____

Please X the box for any conditions or symptoms presently causing you problems.
Please check mark the box for those conditions or symptoms that you have had 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 | | ☐ Ulcer | |
| ☐ Nausea | | ☐ Kidney infection | | ☐ Diabetes | |
| ☐ Clumsiness | | ☐ Bedwetting | | Have you ever had any fractures? | |
| ☐ Numbness or tingling | | ☐ Prostate trouble | | ☐ yes ☐ no | |
| **Muscles and Joints** | | **GU for Women** | | If yes - where? | |
| ☐ Sore/stiff neck | | ☐ Painful menstruation | | Have you ever been in a car accident? | |
| ☐ Mid back ache | | ☐ Excessive flow | | ☐ yes ☐ no | |
| ☐ Low back ache | | ☐ Hot flashes | | If yes - when? | |
| ☐ Painful tailbone | | ☐ Irregular/absent cycle | | Have you ever been hospitalized? | |
| ☐ Shoulder pain | | ☐ Cramping/backache | | ☐ yes ☐ no | |
| ☐ Arm/forearm pain | | ☐ Vaginal discharge | | Why/When? | |
| ☐ Elbow pain | | ☐ Swollen breasts | | Are you currently a smoker? | |
| ☐ Wrist/hand pain | | ☐ Lump in breasts | | ☐ yes ☐ no How much? _____ | |
| ☐ Hip pain | | Currently on birth control pills/patch? | | Did you smoke previously? | |
| ☐ Knee pain | | ☐ yes ☐ no | | ☐ yes ☐ no How much? _____ | |
| ☐ Ankle/foot trouble | | Previously on birth control pills/patch? | | Have you ever been diagnosed: | |
| ☐ Arthritis | | ☐ yes ☐ no | | With cancer? ☐ yes ☐ no | |
| ☐ Loss of strength | | # of pregnancies ____ | | With HIV/AIDS? ☐ yes ☐ no | |
| **Eyes/Ears/Nose/Throat** | | # of children ____ | | With Hep A/B/C? ☐ yes ☐ no | |
| ☐ Failing vision | | **Medications** (list): | | **Vitamins/Supplements** (list): | |
| ☐ Eye pain | | | | | |
| ☐ Failing hearing | | | | | |
| ☐ Earache | | **Wellness/Lifestyle History** | | | |
| ☐ Ring/buzz in ears | | Rate your level: Exercise | | Poor 1 2 3 4 5 Excellent | |
| ☐ Frequent colds | | Diet | | Poor 1 2 3 4 5 Excellent | |
| ☐ Sinus infection | | Sleep | | Poor 1 2 3 4 5 Excellent | |
| ☐ Enlarged thyroid | | General Health | | Poor 1 2 3 4 5 Excellent | |
| ☐ Enlarged glands | | Alcohol: _____ drinks/day | | Caffeine: _____ coffee/tea per day | |
| | | Stress Level | | Low 1 2 3 4 5 High | |

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## CHIEF COMPLAINT

**A** Use the key below to indicate the characteristics of your chief complaint and related symptoms.

**B** How did your symptoms start?

- ☐ Sudden
- ☐ Gradual
- ☐ Car accident
- ☐ Work related injury

**C** When did your symptoms start?

- ☐ 0-3 months
- ☐ 3-6 months
- ☐ 6-9 months
- ☐ >12 months

**D** If you have more than one concern, please list them below in order of priority

| | Concern | Cause? | How Long? | Had Before? When? |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

**E** Please circle the number which best describes your current pain

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Worst Imaginable Pain

## RANSFORD PAIN DIAGRAM

Please indicate on the symptom diagram any of the following:

Numbness: ≡≡≡≡≡≡≡

Pins and needles: o o o o o o

Burning: x x x x x x

Sharp / stabbing: ∽ ∽ ∽ ∽ ∽

Dull and aching: Δ Δ Δ Δ Δ Δ

Stiff and tight: 2 2 2 2 2 2