Harmonic Life Chiropractic Center Health Questionnaire

Name_____ Date of Birth _____Gender M F Phone _____

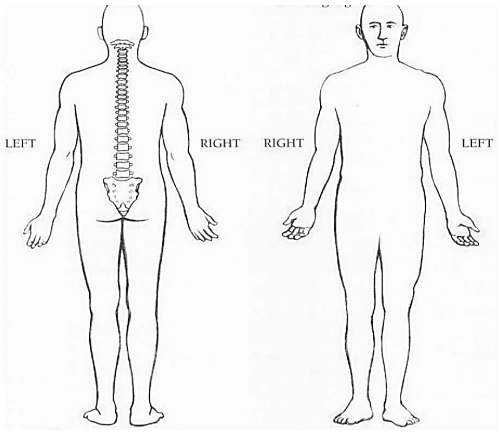
Address_____ City_____ State_____ Zip_____

E-mail Address_____ Occupation_____ # Hours/Wk Working ____

Emergency Contact_____ Phone_____

Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Neck Pain/Stiffness
- ☐ Pain Between Shoulder Blades
- ☐ Numb/Tingling in Arms/Hands
- ☐ Tension Across Top of Shoulders
- ☐ Back Pain/Stiffness
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Tension/Headaches
- ☐ Pain Down Leg(s) or Arm(s)
- ☐ Jaw Pain, TMJ Problems
- ☐ Cancer
- ☐ Organ Transplant
- ☐ Recent Surgery
- ☐ Diabetes
- ☐ Blood Clots/Blood Disorder
- ☐ High/Low Blood Pressure
- ☐ Pregnancy- Due Date _____
- ☐ Infectious Disease
- ☐ Heart, Circulatory Problems
- ☐ Asthma or Lung Conditions
- ☐ Sinus Problems
- ☐ Hernia
- ☐ Arthritis, Tendonitis
- ☐ Muscle or Joint Pain
- ☐ Strains/Sprains
- ☐ Surgical Pins/Plates
- ☐ Allergies to Scents/Oils/Fabric
- ☐ Contact Lenses
- ☐ Carpal Tunnel
- ☐ Fibromyalgia
- ☐ Other Medical Conditions



Indicate by circling, where you have pain or other symptoms

Other (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like? (describe) _____

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work☐
Other_____

Has it been reported? ☐ Yes ☐ No If Yes, to whom? _____

Do you have insurance? ☐ Yes ☐ No Ins. Carrier _____ HMO?☐ Yes ☐ No

How did you hear about us? (**Please check all that apply**)

Friend or family member _____If so, what is their name? _____
Medical Referral _____If so, what is their name and profession? _____
Health Fair or Screening _____ Insurance Provider List _____ Other (Specify) _____

Please select the item which is most appropriate for you

- I would like to come to the Doctor's office for a NO CHARGE consultation. This will allow me to find out if I can be helped by chiropractic without financial barriers.
- I would like to come to a Spinal Health Workshop.

I have completed this form to the best of my knowledge. I understand the massage services and consultation are designed to be a health aid and in no way take the place of a Doctor's care when it is indicated. Information exchanged during any massage session is not intended to be a diagnosis or taken as medical advice. Everything stated on this form is confidential. Our time together is precious, and I agree to cancel 24 hours in advance.

Signature: _____ Date: ____/____/____

Signature of Parent/Guardian_____ Print Name_____ Date_____

Staff Approval Signature_____