HAUPTMAN CHIROPRACTIC CLINIC

SYMPTOM QUESTIONNAIRE

Patient Name:____ Date:________________

Where are you having your major problems? □ Head □ Neck □ Lower Back □ Mid Back □ Shoulders/Arms/Hands □ Hip/Legs/Feet □ Other:

Chief Complaint and Symptoms:____
____
____

How long has this condition lasted?____
Was this caused by: □ Injury □ Accident □ Fall □ None □Other:
Has this happened before?_______________ When?__________________________________
What time of day is pain/condition the worse? □ Morning □ Afternoon □ Evening □ Night □ All the time
Does this interfere with your normal living and work?_______________________________
Describe any falls, accidents, surgeries in the past that may have contributed to your condition:____
____

Family history with similar condition?____
Have you seen another doctor for this? □ No □ Yes If yes, □ DC □ MD □ DO □ PT
Name of doctor:____________________________ Diagnosis:__________________________
Name of hospital:____________________________ X-Rays:___________________________
CT/MRI:____________________________________ Other Tests:________________________
Prior Treatment:__________________________ Result (subjective):___________________
Length of treatment/time under care:____
Past Fractures:___________________________ Past Surgeries:_______________________
Are you pregnant? □ No □ Yes If yes, how many weeks?____________________________
Birth Control? □ No □ Yes If yes, type?____

Are you taking any drugs/medications? □ No □ Yes If yes, describe:___________________
____
Are you taking any vitamins, herbs, or supplements? □ No □ Yes If yes, describe:_______
____
Past or present cancer? □ No □ Yes If yes, describe:________________________________
____
Other:____

***Patient Signature:______________________________________**