# HAUPTMAN CHIROPRACTIC CLINIC
# SYMPTOM QUESTIONNAIRE

**Date:** _____

**Patient:** _____ **Date of Birth:** _____
**Where are you having your major problems? □ Head □ Neck □ Lower Back □ Mid Back**
**□ Shoulders/Arms/Hands □ Hip/Legs/Feet □ Other:** _____

**Chief Complaint/Symptoms:** _____

_____

**How long has this condition lasted?** _____
**Was this caused by: □ Injury □ Accident □ Fall □ None □ Other:** _____

**Has this happened before? □ No □ Yes When?** _____
**Time of day pain/condition is worse? □ Morning □ Afternoon □ Evening □ Night □ All Day**
**Does this interfere with your normal living/work? □ No □ Yes**
**Describe any falls/accidents/surgeries 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 vitamins/herbs/supplements? □ No □ Yes If yes, describe:** _____

_____

**Past or present cancer? □ No □ Yes If yes, describe:** _____

_____

**Other:** _____

***Patient Signature:** _____

**Physician Signature:** _____

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