Medical Sypmtoms Questionnaire

Rate each of the following symptoms based on your typical health for the past month on a scale of 0-4 (4 being the most severe).

Name_____ Date_____

Digestive Tract	Nausea, Vomiting	⓪①②③④
	Diarrhea	⓪①②③④
	Constipation	⓪①②③④
	Bloated feeling	⓪①②③④
	Heartburn	⓪①②③④
	Intestinal, stomach pain	⓪①②③④
	Belching/Passing Gas	⓪①②③④
	Digestive Total:	
Joints/ Muscles	Pain or aches in joints	⓪①②③④
	Arthritis, joint swelling	⓪①②③④
	Stiff/limited movement	⓪①②③④
	Pain or aches in muscles	⓪①②③④
	Feeling of weakness/tired	⓪①②③④
	Joint/Muscles Total:	
Emotional	Mood swings	⓪①②③④
	Anxiety, fear, nervousness	⓪①②③④
	Anger, Irritability, aggression	⓪①②③④
	Depression	⓪①②③④
	Emotional Total:	
Energy/ Sleep	Fatigue, sluggishness	⓪①②③④
	Apathy, lethargy	⓪①②③④
	Hyperactivity	⓪①②③④
	Restlessness, achiness	⓪①②③④
	Sleep disturbances	⓪①②③④
	Energy/Sleep Total:	
Weight/ Food	Binge eating, drinking	⓪①②③④
	Craving certain foods	⓪①②③④
	Excessive weight	⓪①②③④
	Compulsive eating, food addiction	⓪①②③④
	Water retention	⓪①②③④
	Underweight	⓪①②③④
	Weight/Food Total:	
Skin	Acne	⓪①②③④
	Hives, rashes, dry skin, redness	⓪①②③④
	Hair loss	⓪①②③④
	Flushing, hot flashes	⓪①②③④
	Excessive sweating	⓪①②③④
	Skin Total:	
Heart	Irregular or skipped heartbeat	⓪①②③④
	Rapid/pounding heartbeat	⓪①②③④
	Chest pain	⓪①②③④
	Heart Total:	
Other	Frequent illness	⓪①②③④
	Frequent or urgent urination	⓪①②③④
	Genital itch or discharge	⓪①②③④
	Other Total:	

Respiratory	Chest congestion	⓪①②③④
	Asthma, bronchitis	⓪①②③④
	Shortness of breath	⓪①②③④
	Difficulty breathing	⓪①②③④
	Respiratory Total:	
Eyes	Watery or itchy eyes	⓪①②③④
	Swollen, red or sticky eyelids	⓪①②③④
	Bags or dark circles under eyes	⓪①②③④
	Blurred vision	⓪①②③④
	Eyes Total:	
Nose	Stuffy nose	⓪①②③④
	Sinus problems or dripping nose	⓪①②③④
	Hay fever	⓪①②③④
	Sneezing attacks	⓪①②③④
	Excessive mucus	⓪①②③④
	Nose Totals:	
Mouth/ Throat	Frequent, consistent coughing	⓪①②③④
	Gagging, need to clear throat	⓪①②③④
	Sore throat, hoarse, loss of voice	⓪①②③④
	Swollen/discolored tongue, gums or lips	⓪①②③④
	Canker sores, other mouth sores	⓪①②③④
	Mouth/Throat Total:	
Ears	Itchy ears	⓪①②③④
	Earaches, ear infections	⓪①②③④
	Drainage from ear, waxy buildup	⓪①②③④
	Ringing in ears, hearing loss	⓪①②③④
	Ears Total:	
Head	Headaches	⓪①②③④
	Faintness or lightheadedness	⓪①②③④
	Dizziness	⓪①②③④
	Insomnia	⓪①②③④
	Head Total:	
Cognitive	Poor memory, recall	⓪①②③④
	Confusion, poor comprehension	⓪①②③④
	Poor concentration	⓪①②③④
	Poor physical condition	⓪①②③④
	Difficulty in making decisions	⓪①②③④
	Stuttering, stammering	⓪①②③④
	Slurred speech	⓪①②③④
	Learning disabilities	⓪①②③④
	Cognitive Total:	

Total: _____

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Are You Living Well?

How many glasses of water do you drink daily? 0-1_____ 2-4_____ 5-7_____ 8 or more_____

How many servings of caffeine do you have daily? 0-1_____ 2-4_____ 5-7_____ 8 or more_____
(Include coffee, sodas, iced tea, etc.)

How many cigarettes do you smoke per day? 0_____ 2-4_____ 5-7_____ 8 or more_____

How many minutes of exercise to you get each week? 0-30_____ 30-60_____ 60-120_____ >120_____

Do you do anything routinely for stress reduction (meditation, yoga, reading, hobbies)? Yes_____ No_____

How many servings of fruits and/or vegetables do you eat daily? 0-2_____ 3-5_____ 6 or more_____

What supplements do you take? Multi_____ Omega 3 (fish oil)_____ Probiotics_____ Vit D_____ Other_____

Do you use corn or vegetable oil? Yes_____ No_____

How many hours of continuous sleep do you get each night? 1-2_____ 3-5_____ 6 or more_____

How many servings of alcohol do you drink each week? 0-2_____ 3-5_____ 6 or more_____

How many servings of sugar/high fructose corn syrup do you have daily? 0-1_____ 2-5_____ 6 or more_____

How many servings of fried foods do you have each week? 0-2_____ 3-5_____ 6 or more_____

How many prescription drugs do you take daily? 0-2_____ 3-5_____ 6 or more_____

How many over the counter drugs do you take daily? 0-2_____ 3-5_____ 6 or more_____
(Aspirin, Tylenol, Advil, etc.)

In terms of overall health and wellness, please mark with an 'X' where you believe yourself to currently be.

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0 10 20 30 40 50 60 70 80 90 100

Are you as healthy as you were 5 years ago? Yes_____ No_____

Will you be as healthy in 5 more years? Yes_____ No_____

PERSONAL HEALTH GOALS

(Which of the following would you like to change if you could?)

☐ Improve Nutrition/Eating Habits	☐ Lower Cholesterol	☐ Get off Medications
☐ Weight Loss/Fat Loss	☐ Lower Blood Pressure	☐ Improved Sleep
☐ Increase Lean Muscle Mass	☐ Start Exercising	☐ Improved Energy
☐ Increase Bone Density	☐ Look Better	☐ Improved Posture
☐ Reduce Stress	☐ Feel Better	☐ Improved Outlook/Happiness

Please check which statement best describes your want and expectation from chiropractic care in this office:

☐ Relief of pain/symptoms (phase I)
☐ Relief of pain/symptoms as well as long-term correction of the cause of these symptoms (Phase I & II)
☐ Relief and correction of pain/symptoms and strategies for improved health and wellness in the future (Phase III)
☐ I want the doctor to select the type of care for my condition.