Calhoun Spinal Associates, LLC

Health Questionnaire

Name: ____________________________Age____ Home Phone #: _________________ Work Phone #: ___________

Address: _____________________________________City: __________________________ State ____Zip: ________

Occupation: ____________________________# Hours/Week Currently Working:______________________________

E-mail Address: ____Cell Phone #: __________________________

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

☐ Low Back Pain
☐ Pain between Shoulder Blades
☐ Neck Pain
☐ Tension/Headaches
☐ Fibromyalgia
☐ Tension Across Top of Shoulders
☐ Numbness/Tingling in Arms/Hands
☐ Numbness/Tingling in Legs/Feet
☐ Pain in the legs
☐ Pain in the feet
☐ Tired/Fatigued
☐ Difficulty Sleeping
☐ Allergies
☐ Digestive Problems
☐ Carpal Tunnel

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) ____

What have you done that has helped this problem? ____

What activities would you like to do if this was not a problem? ____

Does this cause you to be:
☐ Moody
☐ Irritable
☐ Interrupt sleep
☐ Restricted in your daily activities

Does this affect your work:
☐ Decision making
☐ Poor attitude
☐ Decreased productivity
☐ Exhausted at the end of the day
☐ Unable to work long hours

Does this affect your life:
☐ Lose patience with spouse/children
☐ Restricted household duties
☐ Hinders ability to exercise or sports
☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

◆ Medications…Helped: Little Some Much
◆ Physical Therapy…Helped: Little Some Much
◆ Chiropractic…Helped: Little Some Much
◆ Exercise…Helped: Little Some Much
◆ Nutrition…Helped: Little Some Much
◆ Stretching…Helped: Little Some Much

OTHER ____

Location Date: Apt:

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: ____ **Date:** _____/_____/_____

How did you hear about us? ____