

Dr. Dorothy B. Brolin
Brolin Chiropractic
1300 SE Maynard Road, Suite 202
Cary, NC 27513

Date: _____

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete this form as accurately as possible. Your answers will help us to determine whether chiropractic can help you. If you do not sincerely believe your condition can respond satisfactorily, we will not accept your case. Thank you for your cooperation.

PERSONAL INFORMATION:

Full Name: _____ Age: _____ Birthday: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone # (Home): _____ (Cell) _____ (Work): _____ Social Security #: _____
____ Male ____ Female (Marital Status) M S W D Spouse's Name: _____ Phone # _____
Number of Children: _____ Name(s): _____
E-Mail Address: _____
Occupation: _____ Employer: _____ Referred By: _____
By what name would you like to be addressed in our office: _____
Emergency Contact Name: _____ Phone # _____
Person responsible for bill You and ____ Spouse ____ Worker's Comp. ____ Auto Insurance ____ Medicare ____ Medicaid ____ Health Insurance
Do you have Group Insurance? ____ Yes ____ No - Insurance Company: _____

MEDICAL INFORMATION:

Primary Care Physician: _____ Address: _____
Date of Last: Physical Exam: _____ Blood Pressure Check: _____ X-rays: _____
Medication(s) taken at present time: _____
List surgical operations & dates: _____
Is there any illness in your family? ____ YES ____ NO *If yes, give relation and illness:* _____
How would you grade your general stress level? ____ No Stress ____ Minimal Stress ____ Moderate ____ Greatly Stressed
Physical activity at work: ____ Sedentary more than 50% of workday ____ Light Manual ____ Manual Labor ____ Heavy Manual
General Physical Activity: ____ No regular exercise program ____ Light exercise program ____ Strenuous exercise program

CURRENT COMPLAINTS:

Purpose of this appointment? _____
Present Complaint: _____
When did your problem begin? (*Specific date if possible*) _____
Describe how your problem began: _____
Please describe the character of your current pain (*You may check one or more*):
____ Stabbing ____ Sharp ____ Dull ____ Aches/Sore ____ Throbbing ____ Numbness ____ Burning ____ Tingling ____ Other: _____
Is the pain: ____ Constant (76-100%) ____ Frequent (51-75%) ____ Occasional (26-50%) ____ Intermittent (25% or less)
How bad is your pain or ache? Please circle a number: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)
What makes it better? ____ Nothing ____ Lying Down ____ Walking ____ Standing ____ Exercise ____ Inactivity ____ Other: _____
What makes it worse? ____ Nothing ____ Lying Down ____ Walking ____ Standing ____ Exercise ____ Inactivity ____ Other: _____
Other doctors consulted for this condition?: _____
Treatment given: ____ Surgery ____ Spinal Injections ____ PT ____ A Back Support ____ Medication: _____
____ Spinal Adjustment ____ Other: _____ If none check here: _____
Have you had similar complaints in the past?: ____ Yes ____ No *If yes type of treatment received:* _____

(Continue on back)

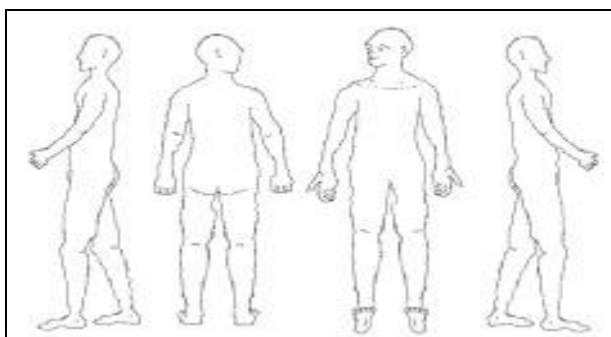
Any prior auto, work or other accident? Give dates and details:

Are your complaints affecting your ability to work or otherwise be active?

- No effect Some physical restrictions (able to perform light duty tasks)
 Need limited assistance with common everyday tasks Need assistance often
 Have a significant inability to function w/o assistant I am totally disabled (impaired)

SYMPTOM LOCALIZATION:

Please mark on the diagram where the complaint is:



SIGNIFICANT PROBLEMS:

General

- Allergy
 Dizziness
 Ear Problems
 Fatigue
 Frequent Colds
 Headaches
 Nose Bleed
 Numbness
 Sinus Infection
 Sore Throat
 Sudden Weight Gain/Loss
 Tonsillitis

Gastrointestinal

- Constipation
 Diarrhea
 Gall Bladder Trouble
 Intestinal Trouble
 Nausea & Vomiting
 Stomach Problems

Respiratory

- Chest Pain
 Chronic Cough
 Difficult Breathing
 Rheumatic Fever

Have you had any the following?

- AIDS
 Alcoholism
 Anemia
 Arthritis
 Cancer
 Diabetes
 Heart Disease
 Mental Disorders
 Nervous Breakdown
 Polio

Genito-Urinary

- Frequent Urination
 Inability to Control Urine
 Kidney Infection / Stones
 Painful Urination
 Prostate Trouble

Muscle & Joint

- Ankle Pain
 Arm Pain
 Elbow Pain
 Foot Trouble / Pain
 Knee Pain
 Leg Pain
 Neck Pain
 Pain between Shoulders
 Painful Low Back
 Rib Pain
 Excessive Sleep (Over 8 Hours)

For Women Only

- Hot Flashes
 Irregular Cycle
 Lumps in Breast
 Painful Menstruation

Cardio-Vascular

- High Blood Pressure
 Heart Condition
 Swelling of Ankles
 Swollen Joints

Habits

- Coffee
 Tea
 Tobacco
 Alcohol

To the best of my knowledge the preceding answers to the questions on this form are the complete truth regarding my health history.

Print Name: _____ Sign: _____ Date: _____

Patient or Guardian