

Universal Chiropractic & Functional Rehabilitation Health Survey

Name: _____

Age: _____

Today's Date: _____

Please Mark ALL Conditions You Have Now of Have Had in the Past:

<p><u>GENERAL</u></p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fevers</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Loss of Sleep</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Bruise Easily</p> <p><input type="checkbox"/> Hernia</p>	<p><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Open Heart Surgery</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Poor Circulation</p> <p><input type="checkbox"/> Fast Heart Rate</p> <p><u>GENITOURINARY</u></p> <p><input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> Frequent Urination</p> <p><input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> Bladder Problems</p> <p><input type="checkbox"/> Prostate Problems</p> <p><u>WOMEN</u></p> <p><input type="checkbox"/> Never Pregnant</p> <p><input type="checkbox"/> Now Pregnant</p> <p><input type="checkbox"/> # of Months _____</p> <p><input type="checkbox"/> Previously Pregnant</p> <p><input type="checkbox"/> # of Births _____</p>	<p><u>SYSTEMIC</u></p> <p><input type="checkbox"/> Aids</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anorexia/Bulemia</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Cold Sores</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Other _____</p>
<p><u>MUSCLE/JOINT</u></p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> Swollen Joints</p> <p><input type="checkbox"/> Whiplash</p> <p><input type="checkbox"/> Foot/Ankle Trouble</p> <p><input type="checkbox"/> Knee Trouble</p> <p><input type="checkbox"/> Hip Trouble</p> <p><input type="checkbox"/> Shoulder Trouble</p> <p><input type="checkbox"/> Elbow Trouble</p> <p><input type="checkbox"/> Wrist Trouble</p> <p><input type="checkbox"/> Jaw Trouble</p>		

FAMILY HISTORY – PLEASE MARK CONDITIONS PRESENT IN YOUR FAMILY

<p><input type="checkbox"/> Auto Immune Disorder Who? _____</p>	<p><input type="checkbox"/> Diabetes Who? _____</p>
<p><input type="checkbox"/> Arthritis Who? _____</p>	<p><input type="checkbox"/> Heart Disease Who? _____</p>
<p><input type="checkbox"/> Back Trouble Who? _____</p>	<p><input type="checkbox"/> Kidney Disease Who? _____</p>
<p><input type="checkbox"/> Cancer Who? _____ Type? _____</p>	<p><input type="checkbox"/> Seizure Disorder Who? _____</p>

Patient's Signature _____ Date _____