Londer Family Chiropractic Center
Dr. Irene Dubinsky Londer
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King of Prussia, Pa 19406
610-783-1311

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition: _____

_____

_____

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each: _____

_____

List anything you are allergic to: _____

_____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

Do you exercise? □ Yes □ No Hours per week _____ What activity(s)? _____

_____

Are you dieting? □ Yes □ No Since: _____ Do you smoke? □ Yes □ No ____packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? _____

Date of last menstrual period: _____

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Patient name/date_____-

Description of Symptoms/Complaints

Describe the reason(s) for your doctor visit today:_____

_____

_____

_____

Are you here because of an accident? ____What type? _____

When did your symptoms start? _____ How did your symptoms begin?

_____

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

_____

_____

Have you experienced these symptoms in the past?_____

_____

History of Treatment

Primary care physician: _____Phone: _____

Date last seen: _____May we update them on your condition? ____Yes _____ No

Have you seen a chiropractor before? ____Yes ____ No Who referred you to us? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

_____

_____

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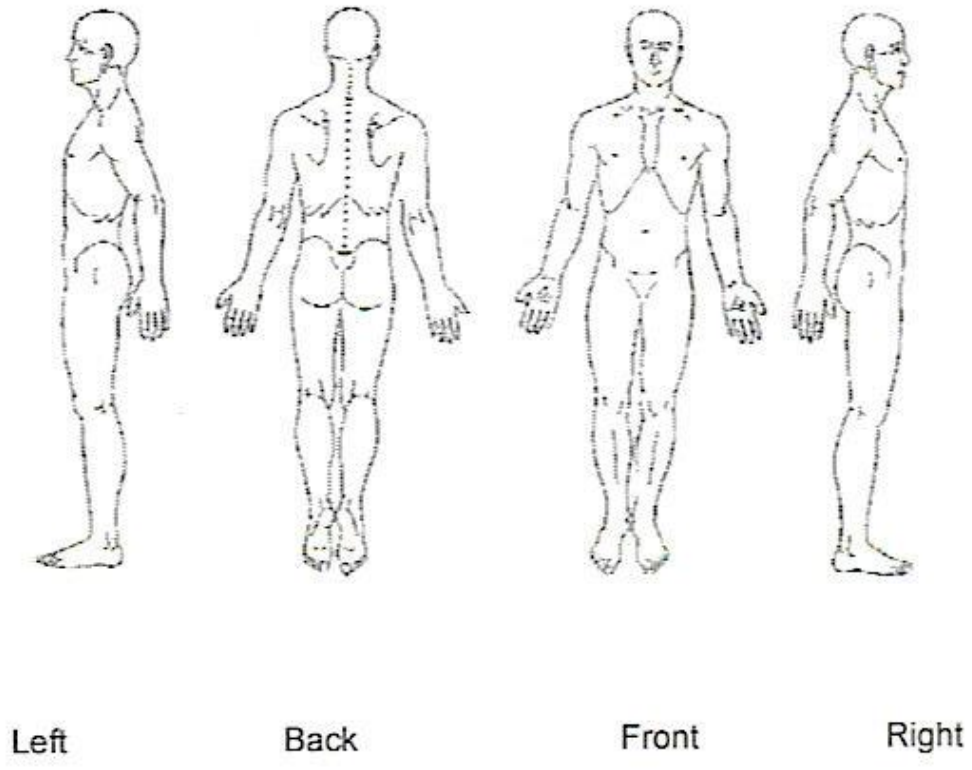
Patient name/date_____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩Unbearable

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain

○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
Past	**Present**	**Condition**	**Past**	**Present**	**Condition**	**Past**	**Present**	**Condition**
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know: _____

_____

_____

_____

Patient's signature: _____ **Doctor's signature:** _____