Chiropractic Health Questionnaire

GRANELLI
SPINAL HEALTH CLINIC

www.granellispinalhealthclinic.com

Date .....

Personal Information			
Name		Email address	
Address			
		Post Code	
Home Telephone No		Mobile	
Date of Birth		Occupation	
GP Name and Address			
		GP Telephone	

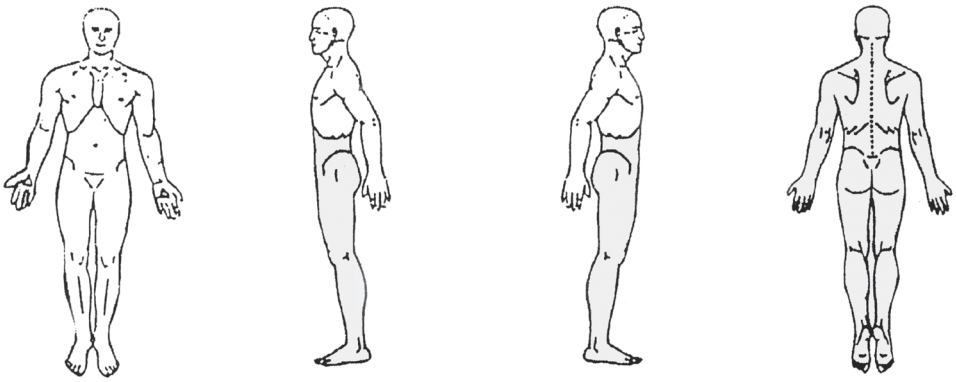
HOW DID YOU HEAR ABOUT THE CLINIC?

General Practitioner ..... ☐ Internet Search ..... ☐ Sign ..... ☐

Friend / Family / Previous Patient ..... ☐ Who ..... Other ..... ☐

Present complaint	
Symptoms	
What makes it worse?	
What helps it?	
Date of onset and duration	
Treatment to date	
Previous diagnosis	
Have you had this or similar conditions in the past?	
X-rays: When were they taken?	
MRI: When was it taken?	
Are you insured with a private health plan?	
Do you want to try and prevent further injury? ☐	Are you interested in improving your overall health and quality of life? ☐
Have you ever seen a chiropractor before?	Yes ☐ No ☐
If so, when and where?	

PLEASE INDICATE ON THE DIAGRAMS WHERE YOU HAVE BEEN EXPERIENCING PAIN



V = PAIN
# = PINS/NEEDLES
⁘ = NUMBNESS

PLEASE INDICATE YOUR AVERAGE LEVEL OF PAIN OVER THE LAST WEEK:

0 1 2 3 4 5 6 7 8 9 10

ARE YOU EXPERIENCING ANY OF THE FOLLOWING (Past or Present)?

Please tick where applicable

Symptom	Past	Present
Teeth grinding	☐	☐
Jaw pain	☐	☐
Clicky jaw	☐	☐
Facial pain	☐	☐
Trigeminal neuralgia	☐	☐
Do you wear a denture?	☐	☐
Upper or lower denture?		
Sinusitis	☐	☐
Meniere's disease	☐	☐
Tinnitus	☐	☐
Deafness	☐	☐
Ear infections	☐	☐
Frequent colds	☐	☐
Frequent sore throats	☐	☐
Persistent runny nose	☐	☐
Recurrent blocked nose	☐	☐
Recurrent snuffly nose	☐	☐
Nose bleeds	☐	☐
Snoring	☐	☐
Hayfever	☐	☐
Bad breath	☐	☐
Dental enamel defects	☐	☐
Cataracts	☐	☐
Macular degeneration	☐	☐
Tension/stress headache	☐	☐
Migraine	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Hiatal hernia	☐	☐
Inguinal hernia	☐	☐
Heartburn/indigestion	☐	☐
Reflux	☐	☐
Stomach ulcer	☐	☐
Helicobacter pylori	☐	☐
Burping/belching	☐	☐
Flatulence/wind	☐	☐
IBS	☐	☐
Lactose intolerance	☐	☐
Constipation	☐	☐
Diarrhoea	☐	☐
Loss of appetite	☐	☐
Unintended loss of weight	☐	☐
Hypermobility	☐	☐

Symptom	Past	Present
Colitis	☐	☐
Ulcerative colitis	☐	☐
Crohns disease	☐	☐
Diverticulitis	☐	☐
Sugar craving	☐	☐
Ever had a tummy bug abroad?	☐	☐
Gall stones	☐	☐
Fatty liver	☐	☐
Raised liver enzymes	☐	☐
Gilberts syndrome	☐	☐
Hepatitis	☐	☐
Alcoholism	☐	☐
Reactions to strong odours	☐	☐
Reactions to medications	☐	☐
Poor tolerance to alcohol	☐	☐
High cholesterol	☐	☐
Kidney stones	☐	☐
Blood in urine	☐	☐
Painful urination	☐	☐
Frequent urination	☐	☐
Poor bladder control	☐	☐
Night time urination	☐	☐
Depression	☐	☐
Anxiety/worrying	☐	☐
Bipolar	☐	☐
Schizophrenia	☐	☐
Anorexia	☐	☐
Bulimia	☐	☐
Anemia	☐	☐
Cracks at corner of mouth	☐	☐
Recurrent Mouth ulcers	☐	☐
Restless leg syndrome	☐	☐
Sore tongue	☐	☐
Eczema	☐	☐
Psoriasis	☐	☐
Dandruff	☐	☐
Acne	☐	☐
Dermatitis	☐	☐
Hives	☐	☐
Skin dryness	☐	☐
Dark circles under eyes	☐	☐
Fainting	☐	☐
Dizziness (vertigo)	☐	☐

Symptom	Past	Present
Lightheaded	☐	☐
Angina	☐	☐
Heart disease/attack	☐	☐
Palpitations	☐	☐
Shortness of breath	☐	☐
Stroke	☐	☐
Asthma	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Fits/Epilepsy	☐	☐
Gout	☐	☐
Morning stiffness	☐	☐
Fibromyalgia	☐	☐
Chronic fatigue syndrome	☐	☐
Cramps	☐	☐
Osteoarthritis	☐	☐
Rheumatoid arthritis	☐	☐
Vitiligo	☐	☐
Lichen planus	☐	☐
Alopecia	☐	☐
Prostate enlargement	☐	☐
Prostate cancer	☐	☐
Cancer other	☐	☐
MSRA	☐	☐
C.Difficile	☐	☐
Meningitis	☐	☐
HIV	☐	☐
Tick bites	☐	☐
Fungal toenails	☐	☐
Athletes foot	☐	☐
Thrush	☐	☐
Live/work in a musty smelling building	☐	☐
Live/work in moldy building	☐	☐
Under / over active thyroid	☐	☐
Cold all the time	☐	☐
Cold hands/feet	☐	☐
Goitre	☐	☐
Lightheaded if stand up fast	☐	☐
Lightheaded if miss a meal	☐	☐
Fatigue mid-afternoon	☐	☐
Fatigue mid-morning	☐	☐
Brain fog	☐	☐

Are there any other symptoms not listed here that you currently have ? .....

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Sleep		Activity	
Do you have difficulty falling asleep?	Yes ☐ No ☐	Average time sitting at desk daily	
Normal time you fall asleep		Average time driving car daily	
Do you wake in the night?	Yes ☐ No ☐	**Medications**	
If yes, how often & why?		List any current medication	
Average morning wake up time			
Do you feel hungry in the morning?	Yes ☐ No ☐	Any anti-biotics in the past 2 years?	Yes ☐ No ☐
Do you feel nauseous in the morning?	Yes ☐ No ☐	Used anti-biotics for more than 2 weeks ever?	Yes ☐ No ☐
What position do you sleep in? Back, side L/R, front		Previous steroids	Yes ☐ No ☐
How many pillows do you use?		Previous anti-depressants	Yes ☐ No ☐
What type? Orthopaedic, feather, synthetic		Anti-psychotics	Yes ☐ No ☐
How old is your mattress?		Previous anti-acids for reflux	Yes ☐ No ☐
Type? Memory, normal sprung. Firm, medium, soft		**Energy**	
Does it have a topper?		On average how would you rate your current energy 1-10	
Allergies / Intolerances			
Do you have any confirmed allergies? Yes ☐ No ☐		If yes please list	
Do you have any food intolerances/foods you avoid or reduce? Yes ☐ No ☐		If yes please list	

Diet	
On an average day what would you eat/drink for:	
Breakfast	
Lunch	
Dinner	
Snacks	
Coffee/tea	
Water	
Fizzy drinks (sugar/diet)	
Alcohol (wine, beer, spirits)	

Sport	
Hobbies/Sports that you participate in regularly	
Is your current problem stopping or hindering you in these activities?	Yes ☐ No ☐

Health		
Any tobacco? Yes ☐ No ☐ If yes how many?	How willing are you to change your diet and lifestyle (with guidance and support) to aid your recovery and overall health (1-10)	
Is there anything that could prevent you from making suggested changes?	Yes ☐ No ☐	

Medical History	
Have you had surgery?	Yes ☐ No ☐ Please give details and date.....
Have you ever broken any bones?	Yes ☐ No ☐ Please give details and date.....
Have you had any of the following?	Vehicle accidents ☐ Sports injuries ☐ Severe falls ☐ Please give details and date.....
Have you ever been concussed or in a coma?	Yes ☐ No ☐ Please give details and date.....
Have you required major treatments, investigative tests, or x-rays in the past?	Yes ☐ No ☐ Please give details and date.....
Are you currently attending hospital or seeing a hospital specialist?	Yes ☐ No ☐ Please give details.....
Do you consider yourself to be under stress?	Marital ☐ Domestic ☐ Financial ☐ Workplace ☐ Is it likely to be ongoing?.....
Is there anything else you feel you should mention about your health?	Yes ☐ No ☐ Please give details.....
Current supplements	

For women only	Yes	No
Pregnant at present	☐	☐
Painful menstruation	☐	☐
Irregular cycle	☐	☐
Excessive flow	☐	☐
Vaginal discharge	☐	☐
Cystitis	☐	☐
Thrush	☐	☐
Hot flushes	☐	☐

For women only	Yes	No
Menopause	☐	☐
Previous miscarriage	☐	☐
Inability to conceive	☐	☐
HRT	☐	☐
Contraceptive pill	☐	☐
PCOS	☐	☐
PMS	☐	☐
Endometriosis	☐	☐

Family History	If any of your blood relatives suffered from the following, please specify who and how old at diagnosis
Arthritis (Osteoarthritis, Rheumatoid)	
Cancer	
Heart Disease	
Stroke	
Diabetes	
Nervous system disorders (Parkinsons, MS)	
Coeliac Disease	
Food allergies / Intolerances	
Bowel disorders (IBS, Crohn's disease, Ulcerative Colitis)	
Skin disorders (Eczema, Psoriasis)	
Haemachromatosis	
Mental health (Depression, anxiety, bipolar, schizophrenia	
Thyroid (over or under)	
Dementia / Alzheimers	
B12 Deficiency / Pernicious anemia	
Osteoporosis	
Hypermobility or Elhers Danlos Syndrome (EDS)	