



Harwood Chiropractic and Massage Centre



Health Status Survey

Patient Name: _____ File #: _____ Date: _____

Please X the box for any conditions or symptoms presently causing you problems.

Please check mark (✓) the box for those conditions or symptoms that you have had in the past.

General Symptoms <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Blackouts <input type="checkbox"/> Headache <input type="checkbox"/> Fever <input type="checkbox"/> Excess sweating <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of weight <input type="checkbox"/> Night pain <input type="checkbox"/> Generalized pain <input type="checkbox"/> Nervousness <input type="checkbox"/> Convulsions <input type="checkbox"/> Loss of sleep		Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic cough <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Difficulty breathing		Skin <input type="checkbox"/> Rashes/itching <input type="checkbox"/> Bruise easy <input type="checkbox"/> Dryness <input type="checkbox"/> Boils <input type="checkbox"/> Hives (allergies)	
Neurologic <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Problem speaking <input type="checkbox"/> Problem swallowing <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Nausea <input type="checkbox"/> Clumsiness <input type="checkbox"/> Numbness or tingling		Cardiovascular <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> High blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Stroke <input type="checkbox"/> Hardening of arteries <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Poor circulation <input type="checkbox"/> Heart/blood disease <input type="checkbox"/> Angina		Gastrointestinal <input type="checkbox"/> Poor appetite <input type="checkbox"/> Indigestion <input type="checkbox"/> Excess hunger <input type="checkbox"/> Belching or gas <input type="checkbox"/> Vomiting <input type="checkbox"/> Pain over stomach <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids (piles) <input type="checkbox"/> Jaundice <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Intestinal worms <input type="checkbox"/> Ulcer <input type="checkbox"/> Diabetes	
Muscles and Joints <input type="checkbox"/> Sore/stiff neck <input type="checkbox"/> Mid back ache <input type="checkbox"/> Low back ache <input type="checkbox"/> Painful tailbone <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Arm/forearm pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Wrist/hand pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Ankle/foot trouble <input type="checkbox"/> Arthritis <input type="checkbox"/> Loss of strength		Genitourinary <input type="checkbox"/> Trouble urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney infection <input type="checkbox"/> Bedwetting <input type="checkbox"/> Prostate trouble		Have you ever had any fractures? <input type="checkbox"/> yes <input type="checkbox"/> no If yes - where? _____ Have you ever been in a car accident? <input type="checkbox"/> yes <input type="checkbox"/> no If yes - when? _____ Have you ever been hospitalized? <input type="checkbox"/> yes <input type="checkbox"/> no Why/When? _____ Are you currently a smoker? <input type="checkbox"/> yes <input type="checkbox"/> no How much? _____ Did you smoke previously? <input type="checkbox"/> yes <input type="checkbox"/> no How much? _____ Have you ever been diagnosed: With cancer? <input type="checkbox"/> yes <input type="checkbox"/> no With HIV/AIDS? <input type="checkbox"/> yes <input type="checkbox"/> no With Hep A/B/C? <input type="checkbox"/> yes <input type="checkbox"/> no	
Eyes/Ears/Nose/Throat <input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Failing hearing <input type="checkbox"/> Earache <input type="checkbox"/> Ring/buzz in ears <input type="checkbox"/> Frequent colds <input type="checkbox"/> Sinus infection <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Enlarged glands		GU for Women <input type="checkbox"/> Painful menstruation <input type="checkbox"/> Excessive flow <input type="checkbox"/> Hot flashes <input type="checkbox"/> Irregular/absent cycle <input type="checkbox"/> Cramping/backache <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Swollen breasts <input type="checkbox"/> Lump in breasts Currently on birth control pills/patch? <input type="checkbox"/> yes <input type="checkbox"/> no Previously on birth control pills/patch? <input type="checkbox"/> yes <input type="checkbox"/> no # of pregnancies _____ # of children _____			
		Medications (list): _____		Vitamins/Supplements (list): _____	
		Wellness/Lifestyle History			
		Rate your level:	Exercise	Poor 1 2 3 4 5 Excellent	
			Diet	Poor 1 2 3 4 5 Excellent	
			Sleep	Poor 1 2 3 4 5 Excellent	
			General Health	Poor 1 2 3 4 5 Excellent	
		Alcohol:	drinks/day	Caffeine:	coffee/tea per day
		Stress Level		Low 1 2 3 4 5 High	