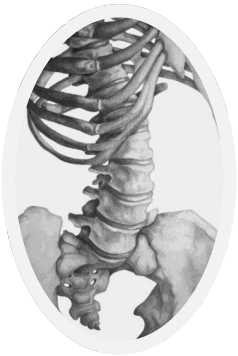

MIQUELI CHIROPRACTIC & MASSAGE THERAPY
910 16TH ST STE 221 DENVER, CO 80202 o 303-573-0984

Patient General Information Questionnaire

Section 1

Personal Data

Patient Name: First _____ Last _____ M.I. _____

Prefers to be called _____ Birth Date _____ M ___ F ___

Parent or Guardian's name if the Patient is a Minor _____

Are you currently pregnant? _____ Have you ever been pregnant? _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Mobile _____

E-mail _____

Current Employer _____ Contact Phone _____

Work Address _____

City _____ State _____ Zip _____

Job Description _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Spouse/ Partner Name _____

Number of Children _____ Ages _____

Emergency Contact Person _____ Phone _____

Section 2

Reason for Care: I am here for a specific condition ____Yes ____ No (If **No** please go directly to Section 3)

Primary Complaint	**Secondary Complaint**	**Tertiary Complaint**
Briefly describe complaint: _____ _____	Briefly describe complaint: _____ _____	Briefly describe complaint: _____ _____
Pain Scale (Circle) Best Worst 0 1 2 3 4 5 6 7 8 9 10	Pain Scale (Circle) Best Worst 0 1 2 3 4 5 6 7 8 9 10	Pain Scale (Circle) Best Worst 0 1 2 3 4 5 6 7 8 9 10
Is it constant? ____ Yes ____ No	Is it constant? ____ Yes ____ No	Is it constant? ____ Yes ____ No
Comes & goes? ____ Yes ____ No	Comes & goes? ____ Yes ____ No	Comes & goes? ____ Yes ____ No
Please check all that describe your current symptoms: ____ Sharp ____ Pins/Needles ____ Stabbing ____ Tingling ____ Dull ____ Numbness ____ Aching ____ Tightness ____ Pinching ____ Other	Please check all that describe your current symptoms: ____ Sharp ____ Pins/Needles ____ Stabbing ____ Tingling ____ Dull ____ Numbness ____ Aching ____ Tightness ____ Pinching ____ Other	Please check all that describe your current symptoms: ____ Sharp ____ Pins/Needles ____ Stabbing ____ Tingling ____ Dull ____ Numbness ____ Aching ____ Tightness ____ Pinching ____ Other
Please check all that aggravate your condition: ____ Driving ____ Breathing ____ Walking ____ Coughing ____ Sitting ____ Sleeping ____ Bending ____ Working ____ Standing ____ Exercising ____ Bowel ____ Other	Please check all that aggravate your condition: ____ Driving ____ Breathing ____ Walking ____ Coughing ____ Sitting ____ Sleeping ____ Bending ____ Working ____ Standing ____ Exercising ____ Bowel ____ Other	Please check all that aggravate your condition: ____ Driving ____ Breathing ____ Walking ____ Coughing ____ Sitting ____ Sleeping ____ Bending ____ Working ____ Standing ____ Exercising ____ Bowel ____ Other
Movements What makes your condition better? ____ Chiropractic ____ Stretching ____ Rest ____ Massage ____ Recumbent ____ Medication ____ Sitting ____ Nothing ____ Standing ____ Other	Movements What makes your condition better? ____ Chiropractic ____ Stretching ____ Rest ____ Massage ____ Recumbent ____ Medication ____ Sitting ____ Nothing ____ Standing ____ Other	Movements What makes your condition better? ____ Chiropractic ____ Stretching ____ Rest ____ Massage ____ Recumbent ____ Medication ____ Sitting ____ Nothing ____ Standing ____ Other
Have you had this current complaint in thee past? ____Y ____N If yes, when? _____	Have you had this current complaint in thee past? ____Y ____N If yes, when? _____	Have you had this current complaint in thee past? ____Y ____N If yes, when? _____
Have you seen any other healthcare providers for your current complaint? ____ Y ____ N	Have you seen any other healthcare providers for your current complaint? ____ Y ____ N	Have you seen any other healthcare providers for your current complaint? ____ Y ____ N

Section 3

Health Habits & Lifestyle

Exercise

Do you exercise? ____ Yes ____ No

How often do you exercise?

_____ days/week _____ hours/day

Stretching/Flexibility ____ Yes ____ No

Running/ Walking ____ Yes ____ No

Rowing/ Swimming ____ Yes ____ No

Competitive Athlete ____ Yes ____ No

Pilates/ Yoga ____ Yes ____ No

Group Exercise ____ Yes ____ No

Weight Lifting ____ Yes ____ No

Other: Please List

_____
_____
_____
_____
_____
_____
_____
_____

Diet

Do you have a healthy diet?___ Yes___ No

How many servings of fruits per day? ____

How many servings of vegetables per day? _____

How many 8oz. glasses of water per day? _____

Do you drink caffeinated beverages?

____ Yes ____ No

How many per day? _____

Pleas list food allergies

_____
_____

Have you ever had an eating disorder?

____ Yes ____ No

Daily Stress Level Scale

Low High

0 1 2 3 4 5 6 7 8 9 10

Have you ever sought help for a mental

Alcohol/Tobacco/Recreational Drug Use

Do you use any of the above?__ Yes __ No

How many cigarettes do you smoke?

_____ / Day or _____ /Week

Do you use smokeless tobacco?__Yes__No

Do you have a history of alcohol use?

____ Yes ____ No

Number of drinks ____ /Day ____ / Week

1 drink is equal to 12 oz. can of beer, 1.5 oz. of liquor, 80 proof, 5 oz. of wine.

Sleeping Pattern

Hours of sleep per night? _____ hours

Please circle appropriate sleep quality.

Excellent Good Fair Poor

Sleep interrupted _____ X/ night

How long? _____ weeks, _____ months, _____ years

Section 4

Personal Health History Please circle all issues below that you have currently or have had in the past.

C= Current P= Past

MUSCLE/JOINT	C	P	EYES/EARS/THROAT	C	P	SKIN	C	P	CARDIOVASCULAR	C	P	GENERAL	C	P
Arthritis	C	P	Thyroid	C	P	Easy Bruising	C	P	Blood Pressure	C	P	Food Allergy	C	P
Back Pain	C	P	Hearing Difficulty	C	P	Psoriasis/Eczema	C	P	Irregular Heart Beat	C	P	Dizziness	C	P
Sciatic Pain	C	P	Vision	C	P	Hives	C	P	Poor Circulation	C	P	Infections	C	P
Bursitis	C	P	DIGESTIVE	C	P	Skin Allergy	C	P	URINARY	C	P	INFECTIOUS DISEASES	C	P
Hip Pain	C	P	Stomach	C	P	Itching	C	P	Kidney	C	P	HIV	C	P
Foot Pain	C	P	Intestinal	C	P	Varicose	C	P	Difficulty Urinating	C	P	Hepatitis	C	P
Neck Pain	C	P	Colon	C	P	PULMONARY	C	P	REPRODUCTIVE	C	P	Tuberculosis	C	P
Headache	C	P	INTERNAL	C	P	Difficulty Breathing	C	P	Menstrual	C	P	ENDOCRINE	C	P
Shoulder Pain	C	P	Liver	C	P	COPD	C	P	Pregnancy	C	P	NEUROLOGICAL	C	P
Arm Pain	C	P	Gall Bladder	C	P	Asthma	C	P	Prostate	C	P	PSYCHOLOGICAL	C	P
Wrist Pain	C	P	Pancreas	C	P	Seasonal Allergy	C	P	Venereal Disease	C	P			

Please list all of the medications you are taking including over the counter medications, herbs & vitamins, and nutritional supplements.

Name/ Dose/ Frequency

_____
_____
_____

Name/ Dose/ Frequency

_____
_____
_____

Medication Allergies _____
_____
_____

Section 5

Please list all accidents, injuries, surgeries & hospitalizations.

Accidents, Injuries, Fractures (Dates) _____
_____

Surgeries (Dates) _____
_____

Hospitalizations (Dates) _____
_____

Pleas list all of your doctors and healthcare providers, including previous chiropractors

Name Phone

_____
_____
_____

Section 6

Family History Please mark the appropriate line with an X.

History	Mother	Father	Brother / Sister	Grandmother	Grandfather
Diabetes	_____	_____	_____	_____	_____
Heart Problems	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____
Kidney Problems	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Headaches	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____
Auto Immune Disorder	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____