

Fiesta Chiropractic Center

HEALTH

SURVEY

Name _____ Phone (Home) _____ Phone (Work) _____
 Address _____ City _____ State _____ Zip _____
 Occupation _____ # Hours Per Week Currently Working _____
 Date of Birth _____ Today's Date _____

1 Check off any of the following symptoms you have experienced in the past 6 months:

- | | | |
|---|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Wrist/Hand Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Tension/Headaches |
| <input type="checkbox"/> Auto Accident/Whiplash | <input type="checkbox"/> "Pinched Nerve" | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Pain Between Shoulder Blades | <input type="checkbox"/> Tension Across Top of Shoulders | |
| <input type="checkbox"/> Tingling/Numbness in Arms or Hands | <input type="checkbox"/> Tingling/Numbness in Legs or Feet | |
| <input type="checkbox"/> Other _____ | | |

Which of the above bothers you the most? _____

How long have you been bothered by the condition? _____

Describe how it feels or affects you when it is at its worst? _____

2	3	4
Indicate below how this causes you to act:	Indicate below how this affects you at work:	Indicate below how this affects your home life:
<input type="checkbox"/> Moody <input type="checkbox"/> Irritable <input type="checkbox"/> Interrupts Sleep <input type="checkbox"/> Short Tempered <input type="checkbox"/> Restricted on Daily Activities Other _____ _____ _____	<input type="checkbox"/> Decision Making <input type="checkbox"/> Exhausted at End of Day <input type="checkbox"/> Decreased Productivity <input type="checkbox"/> Lose Patience With Co- Workers <input type="checkbox"/> Poor Attitude <input type="checkbox"/> Unable to Work Long Hours Other _____ _____ _____	<input type="checkbox"/> Lose Patience with Spouse or Children <input type="checkbox"/> Interferes with Ability to Exercise or to Play Sports <input type="checkbox"/> Restricts Household Duties <input type="checkbox"/> Interferes with Ability to Participate in Hobbies or Other Desired Activities Other _____ _____ _____

Do you have insurance? YES NO PPO POS HMO