Natural Health Houston
Chiropractic & Natural Medicine

Patient Intake Questionnaire

General & Contact Information

Name: _____ Today's Date: _____ Date of Birth: _____

What do you prefer to be called/nickname? _____ Social Security: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ I **give consent** to receive appointment reminder text messages: ❒ Y ❒ N

E-Mail: _____ I **give consent** to receive treatment correspondence via email: ❒ Y ❒ N

Employer/Occupation:

_____

Marital Status: ❒ M ❒ S ❒ W ❒ D Spouse Name (if married): _____ Number of Children: _____

How did you hear about our office? _____

Have you had Chiropractic treatment in the past? ❒ Yes ❒ No When? _____

Doctor's Name _____ What kind of results did you obtain? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Health Information

A. What are your chief symptoms for today's visit?"
   a. _____
   b. _____
   c. _____
   d. _____

   Please describe how the problem began. What was the cause of your health condition?

B. How long have you had this condition? _____
   Have you had this condition in the past? ❒ Yes ❒ No

C. List other medical physicians you have seen for this condition or conditions:

a. _____
b. _____
c. _____
d. _____

D. What type of treatments have you had for your health problem (medically or self-prescribed/at-home)?:

E. List medications you are presently taking:

F. List *any* surgeries you have had in the past and what year:

a. _____ YEAR: _____
b. _____ YEAR: _____
c. _____ YEAR: _____
d. _____ YEAR: _____
e. _____ YEAR: _____

G. What activities aggravate your condition?:

H. Is this condition getting worse? ❒ Yes ❒ No

I. Is this condition interfering with: ❒ work, ❒ sleep, ❒ recreation, ❒ daily routine and/or ❒ other *(please specify)* _____

J. How long has it been since you felt healthy?

_____

K. Do you take supplements? ❒ Yes ❒ No If yes, list which supplements you take:

_____

L. Give a brief description of your job duties:

M. Age of your mattress: _____ Have you worn orthotics (shoe inserts)? ❒ Yes ❒ No

N. On Average, how many hours per night do you sleep? _____

O. Do you have trouble falling asleep? ❒ Yes ❒ No

P. Do you have trouble staying asleep? ❒ Yes ❒ No

Q. Do you toss and turn frequently? ❒ Yes ❒ No

R. Do you wake up tired in the morning? ❒ Yes ❒ No

S. Do you wake up tired with pain in the morning? ❒ Yes ❒ No
   a. If yes, where is that pain located? _____
   b. How severe do you rate the pain on a scale of 1-10, with 10 being the worst? _____

T. Date of last physical exam: _____ Last blood test: _____

U. Name of your primary/family physician: _____

V. What is your blood type: ❒ O ❒ A ❒ B ❒ AB Are you pregnant? ❒ Yes ❒ No

W. Do you smoke? ❒ Yes ❒ No

X. Are your parents still living? ❒ Yes ❒ No If yes, do they have any health problems? ❒ Yes ❒ No
Please list:

Y. If your parents are deceased, what was the cause of death and at what age:
   a. Mother: _____ AGE: _____
   b. Father: _____ AGE: _____

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Z. Please check if you are suffering or have suffered from any of the following health conditions:

- ☐ Osteoporosis
- ☐ Cancer
- ☐ Heart Disease
- ☐ Anxiety/Depression
- ☐ Fibromyalgia
- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Constipation/Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Dysmenorrhea
- ☐ Menopause
- ☐ Hot Flashes
- ☐ Infertility
- ☐ Chronic Fatigue Syndrome
- ☐ Skin Disorders / Eczema
- ☐ Migraines/Headaches
- ☐ Impotence/Prostate
- ☐ PMS
- ☐ Overweight
- ☐ Acid Reflux
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Carpal Tunnel Syndrome
- ☐ Insomnia
- ☐ Multiple Sclerosis
- ☐ Smoking Addiction
- ☐ TMJ
- ☐ Rotator Cuff Problem
- ☐ Tennis Elbow
- ☐ Bursitis/Hip
- ☐ Rib Pain
- ☐ Knee Pain
- ☐ Herniated Disc
- ☐ ADD
- ☐ Gallbladder Problem
- ☐ Ankle Sprains
- ☐ Heel Spurs/Foot Pain
- ☐ Scoliosis
- ☐ Anemia
- ☐ Dizziness/Motion Sickness
- ☐ Hypoglycemia

We thank you for taking the time to fill this form out honestly and to the best of your ability!

Patient Signature: _____ Date: _____