Bullard Chiropractic Clinic

"For Proven Results You Can Feel"

Dr. Rick Radtke, D.C. *Dr. Jason Radtke, D.C.*

725 Pollasky Ave, Suite. 111, Clovis CA 93612 · Phone: (559) 299-8300 · Fax: (559) 299-1835

BullardChiro.com

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by filling out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. If there is anything you wish to bring to our attention that is not on this form, please note it in the **Comments Section** at the bottom of the last page.

Name: _____ Date: _____

Address: _____

City: _____State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email: _____ Social Security #: _____ DOB: _____

Marital Status: __ Married ____Single __ Divorced ____Widowed

Children: ____ Yes ____ No If "Yes", include number of: _____Boys ____ Girls

Emergency Contact:

Name: _____ Relationship: _____

Primary Phone: _____ Alt. Phone: _____

Employer: _____ Occupation: _____

Primary Physician: _____ Phone: _____

Referred by: _____

Have you ever been treated by a chiropractor? _____Yes ____ No If yes, when? _____

What problem(s) you would like us to help you with? _____

_____

When did the problem(s) begin? _____

What is the known cause of your problem(s)? _____

How does this problem interfere with your daily activities? (work, sleep, walking, standing, sitting, etc.)? _____

_____

_____

PAST/CURRENT ILLNESSES (include dates)

☐ Cancer_____ ☐ Diabetes_____ ☐ Hepatitis _____

☐ High Blood Pressure _____ ☐ Heart Disease _____ ☐ Rheumatic Fever _____

☐ Thyroid Disease _____ ☐ Seizure _____ ☐ STDs _____

☐ High Cholesterol _____ ☐ Obesity _____ ☐ Eating disorders _____

☐ Acid Reflux/Heartburn _____ ☐ Fractures/Broken Bones _____

☐ Herniated / Bulging Discs _____ ☐ Osteoporosis _____

☐ Osteoarthritis _____ ☐ Fibromyalgia _____

☐ Other: _____

Surgeries: (Type and Date) _____

_____

Significant Trauma (auto accidents, severe falls, injuries.): _____

_____

Significant Dental Work (Type and Date): _____

_____

Allergies (Drug, Chemicals, Foods): _____

_____

List all medications taken within the last two months (vitamins, drugs, herbs, etc.):

_____

_____

FAMILY MEDICAL HISTORY (please indicate family member by number)

1. Father **2.** Mother **3.** Brother/Sister **4a.** Paternal Grandmother **5a.** Maternal Grandmother
4b. Paternal Grandfather **5b.** Maternal Grandfather

☐ Cancer _____ ☐ Diabetes _____ ☐ Hepatitis _____

☐ High Blood Pressure _____ ☐ Heart Disease _____ ☐ Rheumatic Fever _____

☐ Thyroid Disease _____ ☐ STDs _____ ☐ Seizure _____

☐ High Cholesterol _____ ☐ Obesity _____ ☐ Eating disorders _____

☐ Fractures/Broken Bones _____ ☐ Addictions _____

☐ Other: _____

How many days a week do you exercise (check one)? ☐ **0 – 1** ☐ **2 – 3** ☐ **4 – 5** ☐ **5+**

PAST/CURRENT SYMPTOMS (even if not related to your current problem)

☐ Headaches	☐ Numbness/Tingling in arms/hands/fingers	☐ Numbness/Tingling in legs/feet	☐ Swollen feet/ankles
☐ Swollen hands	☐ Neck/Shoulder Pain	☐ Back Pain	☐ Leg Pain
☐ Cold hands	☐ Cold feet	☐ Dizziness	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Diarrhea	☐ Constipation
☐ Buzzing/Ringing in the ear(s)	☐ Acid Reflux/ Heartburn	☐ Anxiety/ Nervousness	☐ Fatigue
☐ Irritability	☐ Depression	☐ Tension	☐ Hot Flashes
☐ Night Sweats	☐ Cold Sweats	☐ Fever	☐ Hot Flashes
☐ Mood Swings	☐ Ulcers	☐ Menstrual Pain	☐ Menstrual Irregularity

☐ Other (be specific) _____

_____

COMMENTS: _____

_____

_____

_____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that fees are due and payable at the time of service and cannot be deferred to a later time.

Print Name: _____

Signature: _____ Date: _____

(Rev. 2 – July 2016)