Dr. Susan D. Player, DC, DABCI, DACBN

Patient History Form

Personal Info

Last Name_____ First_____

Height_____ Weight_____

Age_____ # of Siblings_____

YOUR MAIN PROBLEMS

Please mark with an (X) the major conditions which you are concerned about, would like eliminated, or desire treatment for:

A01 ○ Overweight
A02 ○ Underweight
A03 ○ Sexual problem
A04 ○ Menopause problem
A05 ○ Heart condition
A06 ○ Blood pressure problem
A07 ○ Digestion trouble
A08 ○ Hip, knee, ankle, foot problem
A09 ○ Diabetes
A10 ○ Skin disorder
A11 ○ Ear or hearing disorder
A12 ○ Sinus trouble
A13 ○ Nervous/emotional trouble
A14 ○ Allergies to food
A15 ○ Nutritional evaluation
A16 ○ Arthritis
A17 ○ Headaches
A18 ○ Female problems
A19 ○ Male problems
A20 ○ Extreme fatigue
A21 ○ Cancer
A22 ○ Circulatory problems
A23 ○ Shoulder, elbow, wrist, hand problem
A24 ○ Lung and/or breathing
A25 ○ Liver and/or gall bladder
A26 ○ Intestine or bowel troubles
A27 ○ Neck and/or spine problems
A28 ○ Eye condition
A29 ○ Nose/throat/mouth problems
A30 ○ Dizziness/balance disorder
A31 ○ Kidney/bladder/urinary problem
A32 ○ Allergies in general
A33 ○ Thorough diagnostic checkup
A34 ○ Sleep problems
A99 ○ Other _____

* PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING THE REST OF THIS QUESTIONNAIRE:
Read each question carefully and circle the appropriate letter for EACH number. N= Never, P= Past, C= Currently
If you do not know the words used, or if you are not sure about a question, then circle the **number.**

EYES

B01 N P C Near sighted (can't see things at a distance)?
B02 N P C Far sighted (can't read small print easily)?
B03 N P C Eyes frequently itch?
B04 N P C Cataracts?
B05 N P C Pain in your eyes?
B06 N P C Eyes bloodshot?
B07 N P C Eyes water?
B08 N P C Eyes feel gritty?
B09 N P C Vision blurred?
B10 N P C Eyelids irritated?
B11 N P C Eye Surgery?
B12 N P C Glaucoma?
B13 N P C Macular Degeneration?

EARS

C01 N P C Difficulty hearing?
C02 N P C Discharge from your ears?
C03 N P C Recurrent ear infections?
C04 N P C Punctured ear drum?
C05 N P C Ear pain?
C06 N P C Excessive ear wax?
C07 N P C Ear Surgery?
C08 N P C Ears ringing/buzzing?

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MOUTH & THROAT

D01 N P C Tongue coated?
D02 N P C Bad breath?
D03 N P C Sores or cracks at corners of mouth?
D04 N P C Gum recession or surgery?
D05 N P C Fever blisters?
D06 N P C Gums bleed when you brush your teeth?
D07 N P C Sore throats?
D08 N P C Glands swollen?
D09 N P C Toothaches?
D10 N P C Mouth often dry?
D11 N P C Have excessive saliva?
D12 N P C Sour taste in your mouth?
D13 N P C Sore tongue?
D14 N P C Can't taste food?
D15 N P C Mouth or Throat Cancer?
D16 N P C Family history of mouth/throat cancer?
D17 N P C Silver fillings?
D18 N P C Teeth removed?
D19 N P C Wear braces?
D20 N P C Root Canals?
D21 N P C Mouth or throat surgery?
D22 N P C Clench or grind teeth?

CARDIOVASCULAR

F01 N P C High blood pressure?
F02 N P C Low blood pressure?
F03 N P C Pains in the heart or chest?
F04 N P C Blood clots?
F05 N P C Cold hands?
F06 N P C Feet frequently cold?
F07 N P C Varicose veins? Spider veins?
F08 N P C Ankles frequently swollen?
F09 N P C Unusually slow pulse rate?
F10 N P C Spells of rapid heart beat?
F11 N P C Heart skipping beats?
F12 N P C Shortness of breath while sitting still?
F13 N P C Leg cramps after retiring to bed?
F14 N P C Leg cramps during the day?
F15 N P C Pain in your leg/hips when walking?
F16 N P C Heart attack?
F17 N P C Stroke?
F18 N P C Heart or blood vessel surgery?
F19 N P C High Cholesterol?
F20 N P C Family history of high blood pressure?
F21 N P C Family history of heart disease?
F22 N P C Family history of stroke?

RESPIRATORY

E01 N P C Frequent colds?
E02 N P C Nasal polyps?
E03 N P C Sinus infections?
E04 N P C Night sweats?
E05 N P C Hay fever?
E06 N P C Wheeze?
E07 N P C Asthma?
E08 N P C Difficulty breathing?
E09 N P C Chronic cough?
E10 N P C Spit up phlegm?
E11 N P C Spit up blood?
E12 N P C Spells of sneezing?
E13 N P C Nose frequently stuffy?
E14 N P C Nose run constantly?
E15 N P C Frequent nose bleeds?
E16 N P C Severe colds?
E17 N P C Chronic chest condition?
E18 N P C Post nasal drip?
E19 N P C Difficulty Smelling?
E20 N P C Lung Cancer?
E21 N P C Pneumonia?
E22 N P C Lung, sinus or nose Surgery?
E23 N P C Family history of lung cancer?
E24 N P C Snore?

DIGESTIVE

G01 N P C Appetite poor?
G02 N P C Excessive hunger?
G03 N P C Fainting spells when hungry?
G04 N P C Eating relieves fatigue?
G05 N P C Feel shaky when hungry?
G06 N P C Frequently drowsy after eating a meal?
G07 N P C Eat when nervous?
G08 N P C Frequently have diarrhea?
G09 N P C Difficulty in swallowing?
G10 N P C Vomit frequently?
G11 N P C Frequently nauseated?
G12 N P C Bloated after eating?
G13 N P C Abdominal gas?
G14 N P C Greasy foods cause indigestion?
G15 N P C Belch or burp after eating?
G16 N P C Indigestion immediately upon eating?
G17 N P C Indigestion within 1 hour after meals?
G18 N P C Indigestion 2 hours or more after meals?
G19 N P C Loose bowel movements?
G20 N P C Intestinal worms?
G21 N P C Pale or yellow colored stools?
G22 N P C Constipation?
G23 N P C One or less bowel movements daily?

Patient History Form

DIGESTIVE (cont.)

G24 N P C Bloody stools?
G25 N P C Black tarry stools?
G26 N P C Use laxatives?
G27 N P C Severe abdominal pains?
G28 N P C Hemorrhoids (piles)?
G29 N P C Stomach/duodenal ulcers?
G30 N P C Gall bladder problems?
G31 N P C Liver problems?
G32 N P C Low cholesterol? (less than 140)
G33 N P C Gall stones?
G34 N P C Digestive system cancer?
G35 N P C Digestive system surgery?
G36 N P C Family history of digestive problems?
G37 N P C Family history of digestive cancer?

NEUROMUSCULAR

H01 N P C Neck pain?
H02 N P C Pain between the shoulders?
H03 N P C Low back pain?
H04 N P C Swollen joints?
H05 N P C Spinal curvature (scoliosis)?
H06 N P C Muscle spasms?
H07 N P C Muscles frequently sore?
H08 N P C Muscle weakness?
H09 N P C Joints stiff in the morning?
H10 N P C Shoulder, arm, elbow, wrist, hand problem?
H11 N P C Leg pain at rest?
H12 N P C Any part of your body experience numbness/tingling?
H13 N P C Frequent headaches?
H14 N P C Often dizzy?
H15 N P C Frequently feel faint?
H16 N P C Epilepsy?
H17 N P C Bite your nails badly?
H18 N P C Stutter or stammer?
H19 N P C Sleep walker?
H20 N P C Rheumatoid arthritis?
H21 N P C Osteoarthritis?
H22 N P C Motion sickness?
H23 N P C Hip, knee, ankle problem?
H24 N P C Bone or joint surgery?
H25 N P C Broken bones?
H26 N P C Jaw joint(s) crack, pop, hurt?
H27 N P C Family history of scoliosis?
H28 N P C Tremors?

FEET

I01 N P C Painful feet?
I02 N P C Frequent foot cramps?
I03 N P C Plantar warts?
I04 N P C Heel spurs?
I05 N P C Corns?
I06 N P C Foot surgery?

URINARY

J01 N P C Frequent urination?
J02 N P C Awaken at night to urinate?
J03 N P C Bed wetter?
J04 N P C Dribble when sneezing or laughing?
J05 N P C Lose control of your bladder?
J06 N P C Painful urination?
J07 N P C Blood in your urine?
J08 N P C Urgent urination?
J09 N P C Difficulty in starting the stream?
J10 N P C Frequent bladder infections?
J11 N P C Frequent kidney infections?
J12 N P C Kidney stones?
J13 N P C Urinary system cancer?
J14 N P C Urinary system surgery?
J15 N P C Family history of bladder/kidney cancer?

ENDOCRINE

K01 N P C Excessive thirst?
K02 N P C Frequently feel cold?
K03 N P C Frequently feel hot?
K04 N P C Unusually tired most of the time?
K05 N P C Unusually jumpy or nervous?
K06 N P C Hair coarse?
K07 N P C Hair loss/thinning?
K08 N P C Skin scaly/dry?
K09 N P C Diabetic?
K10 N P C Lightheaded when standing quickly?
K11 N P C Decreased sexual interest?
K12 N P C Cancer of any glands?
K13 N P C Surgery on any gland?
K14 N P C Family history of Diabetes?
K15 N P C Family history of thyroid problems?

FOR MEN ONLY

L01 N P C Painful genitals?
L02 N P C Prostate trouble?
L03 N P C Lumps in your testicles?
L04 N P C Discharge from the urethra?
L05 N P C Sores on external genitalia?
L06 N P C Difficulty getting or keeping an erection?
L07 N P C Difficulty completing intercourse?
L08 N P C Difficulty fathering children?
L09 N P C Sexually transmitted disease?
L10 N P C Reproductive organ surgery?
L11 N P C Family history of prostate or testicle cancer?
L12 N P C Decreased sexual interest?
L13 N P C Sexually abused?

FOR WOMEN ONLY

M01 N P C Painful periods?
M02 N P C Excessive flow?
M03 N P C Irregular cycles?
M04 N P C Menstrual cramps?
M05 N P C Hot flashes?
M06 N P C Vaginal discharge?
M07 N P C Bloody spotting discharge?
M08 N P C Hysterectomy?
M09 N P C Retain fluid before your periods?
M10 N P C Acne worse before period?
M11 N P C Tender breasts?
M12 N P C Frequent yeast infections?
M13 N P C Lumps in your breasts?
M14 N P C Breast implants? Type: _____
M15 N P C Heavy hair growth on face or body?
M16 N P C Take birth control pills?
M17 N P C Pre-menstrual mood changes?
M18 N P C Intercourse painful?
M19 N P C Diminished sex desire?
M20 N P C Poor or infrequent orgasm?
M21 N P C Difficulty getting pregnant?
M22 N P C Uterine fibroids?
M23 N P C Ovarian cysts?
M24 N P C Breast or Reproductive organ surgery?
M25 N P C Sexually transmitted disease?
M26 N P C Breast or Reproductive organ cancer?
M27 N P C Pregnancy? How many? _____
M28 N P C Abortion? How many? _____
M29 N P C Ever miscarried? How many? _____
M30 N P C Epidural anesthetic?
M31 N P C Family history of breast or reproductive cancer?
M32 N P C Sexually abused?
M33 Last pelvic/pap exam? _____
M34 _____ Date of last menstrual period.
M35 _____ Age when periods started.
M36 _____ Number of days from start of one cycle to start of next.

SKIN

N01 N P C Skin tender?
N02 N P C Skin itch?
N03 N P C Skin eruptions?
N04 N P C Is skin rough, especially on the back of arms?
N05 N P C Psoriasis?
N06 N P C Bruise easily?
N07 N P C Acne?
N08 N P C Warts?
N09 N P C Eczema?
N10 N P C Moles which are changing in size or color?
N11 N P C Hives?
N12 N P C Excessive perspiration?
N13 N P C Sores that are slow to heal?
N14 N P C Skin cancer?
N15 N P C Skin surgery?
N16 N P C Family history of skin cancer?

GENERAL

O01 N P C Difficulty falling asleep?
O02 N P C Difficulty staying asleep?
O03 N P C Recurrent bad dreams?
O04 N P C Difficulty concentrating?
O05 N P C Poor memory?
O06 N P C Often cry?
O07 N P C Use antiperspirants?
O08 N P C Easily angered?
O09 N P C Under considerable emotional stress?
O10 N P C Overweight?
O11 N P C Underweight?
O12 N P C Cell phone/cordless phone use?
O13 N P C Sleep less than seven hours per night?
O14 N P C Rarely exercise?
O15 N P C Smoke or chew tobacco?
O16 N P C Exposed to 2nd hand smoke?
O17 N P C Drink alcoholic beverages?
O18 N P C Eating disorder?
O19 N P C Sensitive to chemicals or fragrances?
O20 N P C Tattoos/piercings?
O21 N P C Use perfume/scented products?
O22 N P C Psychiatric care or drugs?
O23 N P C Sleep on stomach?
O24 N P C Allergies?
O25 N P C Family history of allergies?
O26 N P C Have pets?
O27 N P C Blood transfusion?
O28 N P C Sexually active?
O29 N P C HIV positive test?
O30 N P C Type of birth control used? _____
O31 N P C Reconstructive/cosmetic surgery?
O32 N P C Use hair color?
O33 N P C Play sports?
O34 N P C Use pesticides on pets, home or lawns?
O35 N P C Travel to underdeveloped countries?
O36 N P C On disability? Partial?_____ Full?_____

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Patient History Form

DRUGS (RECREATIONAL)

P01 N P C Marijuana?
P02 N P C Cocaine?
P03 N P C LSD?
P04 N P C Speed?

OTHERS (list)

P05 P C _____

P06 P C _____

P07 P C _____

DRUGS (MEDICINAL)

Q01 N P C Tylenol/Motrin/Aleve?
Q02 N P C Aspirin?
Q03 N P C Inhalers?
Q04 N P C Antihistamines?
Q05 N P C Antibiotics?
Q06 N P C Pain killers?
Q07 N P C Steroids? Cortisone injections?

OTHERS (list)

Q08 P C _____

Q09 P C _____

Q10 P C _____

SUPPLEMENTS (list)

R01 P C _____

R02 P C _____

R03 P C _____

R04 P C _____

R05 P C _____

R06 P C _____

FALLS (list)

	When?	Area Injured?
S01	_____	_____
S02	_____	_____
S03	_____	_____
S04	_____	_____

ACCIDENTS (list)

	When?	Area Injured?
T01	_____	_____
T02	_____	_____
T03	_____	_____
T04	_____	_____

ANYTHING ELSE DR. PLAYER SHOULD BE AWARE OF REGARDING YOUR HEALTH? (list)

U01 P C _____

U02 P C _____

U03 P C _____

U05 P C _____

U06 P C _____

U07 P C _____

U08 P C _____

U09 P C _____