

REVIEW OF SYSTEMS & PFSH & PATIENT-CENTERED QUESTIONNAIRE: Patient or parent/guardian is to fill this form out completely. Please do not leave questions unanswered. (Takes 10 minutes) (REV 9/15)

PATIENT NAME: _____

DATE: _____

PATIENT-CENTERED QUESTIONNAIRE: To be filled out by patient. Circle "A" or "B"

A: I have no particular health problem, condition or injury. I am here for a routine chiropractic check-up. (If you circle 'A', do not proceed below.)

B: I have one or more health problems, conditions or injuries that I would like Dr. Collins to focus on. (If you circle 'B', then proceed below.)

- 1) WHAT IS YOUR MAIN HEALTH PROBLEM/ CONDITION/ INJURY?
- 2) WHAT CAUSED IT AND WHEN DID IT BEGIN?
- 3) WHAT DO THINK IS CAUSING YOUR SYMPTOMS?
- 4) HOW SEVERE IS IT? (Mild, moderate or severe)
- 5) HOW LONG DO YOU BELIEVE IT WILL LAST?
- 6) WHAT TREATMENT HAVE YOU DONE SO FAR?
- 7) WHAT KIND OF TREATMENT DO YOU THINK MIGHT HELP YOU?
- 8) WHAT RESULTS DO YOU EXPECT FROM TREATMENT?
- 9) WHAT ARE THE MAIN EFFECTS THIS PROBLEM/CONDITION/INJURY HAS ON YOUR LIFE?
- 10) WHAT DO YOU FEAR MOST ABOUT THIS PROBLEM/CONDITION/INJURY, IF ANYTHING?
- 11) WHICH TYPE OF CHIROPRACTIC CARE WOULD YOU LIKE TO RECEIVE? (CIRCLE A, B, or C)
 - A) RELIEF CARE (GET PROPER DIAGNOSIS AND FOCUS ON RELIEF OF SYMPTOMS MAINLY)
 - B) RELIEF AND CORRECTIVE CARE (CORRECT & MINIMIZE THE UNDERLYING CAUSES)
 - C) RELIEF and CORRECTIVE and MAINTENANCE (MAINTENANCE AND PREVENTION CARE TOO)

PLEASE LIST ANY/ALL MEDICATIONS (NOT INCLUDING HERBS/VITAMINS) THAT YOU TAKE:

Do you **currently** experience, or have you **regularly experienced in the past** and of the following?

- Eye/ Vision Problems: NO / YES
- Ear/ Hearing problems: n / y
- Sinus/Nose Problems: n / y
- Heart Problems: n / y
- High Blood Pressure: n / y
- High Cholesterol: n / y
- Lung/ Breathing Problems: n / y
- Digestion Problems: n / y
- Problems w/ Bowels: n / y
- Problems w/ Urination: n / y
- Dizziness: n / y
- Blood Sugar Problems: n / y
- Allergies: n / y
- Fatigue/ Tiredness: n / y
- Anxiety or Depression: n / y
- (Men) Erection Difficulty: n / y
- Weakness: n / y
- Headache: n / y
- Joint Problems: n / y
- Skin/Hair/Nail Problems: n / y
- Tingling or Numbness: n / y
- (Women) Menstrual Problems: n / y
- (Women) Ovary/ Uterine Problems: n / y
- Sleep Problems: n/y

List Any and All Significant Past Illnesses: _____

List All Hospitalizations & Surgeries: _____

List Any and All Past Major Injuries: _____

Describe Major Illnesses That May "Run In Your Family":

Your Work or Daily Activity Is (circle one from each):

- 1-Sedentary, Somewhat Physical, Moderately Physical, Very Physical
- 2-Not stressful, Mildly Stressful, Moderately Stressful, Very Stressful

Describe Your Living Situation (i.e. married, 2 kids):
