



Magnolia Chiropractic, P.A.

Providing Family Health Care for Our Community

139 S. Main Street
Irving, TX 75060

(972) 554-1511

www.MagnoliaChiro.com

Patient Health Questionnaire			
Last Name:		First Name:	
		M.I.:	
If you have ever had a symptom listed below in the past , please check that symptom in the Past column. If you are presently troubled by a particular symptom, check that symptom in the Present column. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.			

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (Chronic Lung Disease)	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stroke Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint (s)
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ear noises)
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other

If a family member has had any of the following, please mark the appropriate box.

- Cancer Chronic Back Problems Chronic Headaches Diabetes Epilepsy Heart Problems High Blood Pressure
 Lung Problems Lupus Rheumatoid Arthritis Other _____

Present Weight _____ pounds

Height _____ feet _____ inches

Do you have a permanent disability rating? YES NO

Location: _____ Date Rating Received: ____/____/____ Rating Percentage _____%

FOR WOMEN ONLY

Date of last menstrual cycle: ____/____/____

Are you taking birth control pills? Yes No Do you have breast implants? Yes No Are you pregnant? Yes No

If Yes, due date? _____ Are you nursing? Yes No

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages.

Patient's Signature: _____ Date: _____