Coastal Chiropractic & Wellness Center
Dr. Karen Bannon-Boisvert, D.C.

Confidential Health Questionnaire

Name (First, M, Last) _____ Date of Birth ____/____/_____
Emergency Contact _____ Telephone _____
Primary Care Physician _____

Have you had previous Chiropractic Care? ○ Yes ○ No
If yes, name and address (optional) _____
_____

○ Yes ○ No Do you have cardiac or circulatory problems?
○ Yes ○ No Do you have high blood pressure?
○ Yes ○ No Do you suffer from epilepsy or seizures?
○ Yes ○ No Do you smoke? If yes, how many packs/week? _____
○ Yes ○ No Do you take birth control pills?
○ Yes ○ No Do you have Diabetes?
○ Yes ○ No Do you have numbness or stabbing pains anywhere?
○ Yes ○ No Does your pain increase with coughing, sneezing or moving your bowels?
○ Yes ○ No Do you have prostate problems?
○ Yes ○ No Are you pregnant?
○ Yes ○ No Do you suffer from arthritis?
○ Yes ○ No Do you suffer from joint swelling?
○ Yes ○ No Do you have osteoporosis?
○ Yes ○ No Have you ever fractured a bone?
○ Yes ○ No Have you had severe trauma or an accident in the past 2 years?
○ Yes ○ No Have you ever had surgery?
○ Yes ○ No Do you have any contagious diseases?
○ Yes ○ No Are you currently being treated elsewhere for the same health concern that brings you to this office now?
○ Yes ○ No Does anyone in your family suffer from a hereditary disease?

Health problems not mentioned above: _____
_____
Medications: _____
Supplements, vitamins: _____
Further explain any question (from above list) to which you answered *yes.* _____
_____
_____
_____

Doctor's signature: _____ Date: _____