

Wenger Chiropractic Group

PATIENT SYMPTOM SURVEY

DATE _____

PATIENT'S NAME _____ AGE _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____ O₂ _____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time...

Primary Complaints

- | | | |
|--|--|--|
| 090 <input type="checkbox"/> General Good Health | 039 <input type="checkbox"/> High Blood Pressure I10 | 063 <input type="checkbox"/> Prostate Disorder N42.9 |
| 091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis | 040 <input type="checkbox"/> Low Blood Pressure I95.9 | 069 <input type="checkbox"/> Hyperthyroidism E05.90 |
| 001 <input type="checkbox"/> Skin Disorder L25.9 | 041 <input type="checkbox"/> Tachycardia (High Heart Rate) R00.0 | 070 <input type="checkbox"/> Hypothyroidism E03.9 |
| 002 <input type="checkbox"/> Acne L70.8 | 042 <input type="checkbox"/> Numbness R20.9 | 071 <input type="checkbox"/> Systemic Lupus M32.10 |
| 003 <input type="checkbox"/> Psoriasis L40.8 | 043 <input type="checkbox"/> Constipation K59.00 | 072 <input type="checkbox"/> Infertility, female N97.9 |
| 004 <input type="checkbox"/> Urticaria (Hives) L50.9 | 044 <input type="checkbox"/> Indigestion K30 | 073 <input type="checkbox"/> Interstitial Cystitis N30.11 |
| 005 <input type="checkbox"/> ADD/ADHD F90.1/F90.9 | 045 <input type="checkbox"/> Ulcerative Colitis K51.90 | 074 <input type="checkbox"/> Irregular Menstrual Cycle N92.6 |
| 006 <input type="checkbox"/> Allergies, Unspecified J30.9 | 046 <input type="checkbox"/> Depression F32.9 | 075 <input type="checkbox"/> Menopausal Symptoms N95.1 |
| 007 <input type="checkbox"/> Allergic Rhinitis from food J30.5 | 047 <input type="checkbox"/> Diabetes Mellitus E11.9 | 076 <input type="checkbox"/> Hot Flashes N95.1 |
| 008 <input type="checkbox"/> Sinusitis J01.90 | 030 <input type="checkbox"/> Diabetes Type I E10.9 | 077 <input type="checkbox"/> Mental Disorder F99 |
| 009 <input type="checkbox"/> Alzheimer's G30.9 | 031 <input type="checkbox"/> Diabetes Type II E11.65 | 078 <input type="checkbox"/> Insomnia G47.00 |
| 010 <input type="checkbox"/> Poor Concentration/Memory F07.8 | 029 <input type="checkbox"/> Hyperglycemia [high blood sugar] R73.09 | 079 <input type="checkbox"/> Mouth/Throat/Tongue |
| 011 <input type="checkbox"/> Parkinson's Disease G20 | 048 <input type="checkbox"/> Hypoglycemia [low blood sugar] E16.2 | 080 <input type="checkbox"/> Canker Sores K12.0 |
| 012 <input type="checkbox"/> Anemia D64.9 | 049 <input type="checkbox"/> Dizziness/Balance Problem R42 | 081 <input type="checkbox"/> Overweight E66.3 |
| 013 <input type="checkbox"/> Arthritic Disorder M12.9 | 050 <input type="checkbox"/> Ear Infection H65.90 | 082 <input type="checkbox"/> Underweight R63.6 |
| 014 <input type="checkbox"/> Osteoporosis M81.0 | 051 <input type="checkbox"/> Epstein Barr B27.90 | 083 <input type="checkbox"/> Sexual Disorder F66 |
| 015 <input type="checkbox"/> Asthma J45.909 | 052 <input type="checkbox"/> Eye Problems H57.13 | 084 <input type="checkbox"/> Spinal Problems M53.9 |
| 016 <input type="checkbox"/> Emphysema J43.9 | 053 <input type="checkbox"/> Cataracts H26.9 | 085 <input type="checkbox"/> Obesity E66.9 |
| 017 <input type="checkbox"/> Cancer | 054 <input type="checkbox"/> Glaucoma H40.9 | 086 <input type="checkbox"/> GERD K21.9 |
| 018 <input type="checkbox"/> Breast C50.919female C50.929male | 055 <input type="checkbox"/> Macular Degeneration H35.30 | 087 <input type="checkbox"/> HIV B20 |
| 019 <input type="checkbox"/> Prostate C61 | 056 <input type="checkbox"/> Fever R50.9 | 088 <input type="checkbox"/> Crohn's Disease K50.90 |
| 020 <input type="checkbox"/> Lung C34.90 | 057 <input type="checkbox"/> Fibromyalgia M79.7 | 089 <input type="checkbox"/> Irritable Bowel Syndrome K58.9 |
| 021 <input type="checkbox"/> Colon and Rectal C18.9 | 058 <input type="checkbox"/> Gallbladder Disorder K82.9 | 092 <input type="checkbox"/> Normal Pregnancy Z33.1 **only applicable if currently pregnant |
| 022 <input type="checkbox"/> Skin C44.90 | 059 <input type="checkbox"/> Gout M10.9 | 093 <input type="checkbox"/> Shingles B02.9 |
| 023 <input type="checkbox"/> Leukemia w/o remission C95.90 Leukemia w/ remission C95.91 | 060 <input type="checkbox"/> Headaches R51 | 140 <input type="checkbox"/> Migraines G43.909 |
| 024 <input type="checkbox"/> Lymphoma, malignant C85.89 | 061 <input type="checkbox"/> Hearing Loss H91.90 | 141 <input type="checkbox"/> Rheumatoid Arthritis M06.9 |
| 025 <input type="checkbox"/> Brain Tumor, malignant C71.9 | 062 <input type="checkbox"/> Infertility, male N46.9 | 142 <input type="checkbox"/> Non-Systemic Lupus L93.0 |
| 027 <input type="checkbox"/> Anxiety Disorder F41.9 | 064 <input type="checkbox"/> Liver Disease K76.9 | 143 <input type="checkbox"/> Multiple Sclerosis G35 |
| 028 <input type="checkbox"/> Autism F84.0 | 065 <input type="checkbox"/> Hepatitis K71.6 | 144 <input type="checkbox"/> ALS (Lou Gehrig's) G12.21 |
| 033 <input type="checkbox"/> Edema R60.9 | 066 <input type="checkbox"/> Hepatitis B B16.9 | 145 <input type="checkbox"/> Polymyalgia Rheumatica M35.3 |
| 034 <input type="checkbox"/> Eczema L25.9 | 067 <input type="checkbox"/> Hepatitis C B17.10 | 146 <input type="checkbox"/> Scleroderma M34.9 |
| 035 <input type="checkbox"/> Chronic Fatigue R53.82 | 068 <input type="checkbox"/> Kidney Disorder N28.9 or Bladder Disorder N32.9 | 171 <input type="checkbox"/> Goiter E04.9 |
| 036 <input type="checkbox"/> Circulatory Disorder I99.9 | | 178 <input type="checkbox"/> Raynaud's Syndrome I73.00 |
| 037 <input type="checkbox"/> Heart Disease I51.9 | | 179 <input type="checkbox"/> Hemochromatosis E83.119 |
| 038 <input type="checkbox"/> High Cholesterol E78.0 | | 180 <input type="checkbox"/> Thalassemia D56.8 |
| | | 181 <input type="checkbox"/> Brain aneurysm I61.9 |

If necessary, please state your most significant concern...

General Health

- 100 Fingernail base is pink
101 Fingernail base is purple
102 Fingernails have ridges or white spots
103 Fingernails are soft
104 Fingernails are splitting
105 Fingernails peel
106 Pale fingernail beds
107 Blacks out easily
108 Balance problems
109 Difficulty walking
110 Has tattoos
111 Brittle hair
112 Dry hair
113 Thin hair
114 Hair loss
115 Drinks alcoholic beverages daily
116 Drinks less than 8 glasses of water per day
117 Currently on Chemotherapy
118 Currently on radiation treatment
119 Had chemotherapy in the past
120 Has had radiation treatments in the past
121 Gained over 20 lbs in the last 12 months
122 Somewhat Overweight
123 Somewhat Underweight
- 124 Unexplained loss of >20lbs in last 4 months
125 Energy level is worse than it was 5 years ago
127 Sleeps less than 6 hours per night
128 Unable to recall dreams the next day
129 Sensitive to chemicals, paint, fumes, cologne
130 Had blood transfusion in the past
131 Had transplant in the past
138 Takes anti-rejection drugs
132 Had a major accident or injury
137 Sleep Apnea
139 Toxic chemical exposure
175 Has been out of the country recently
176 Had childhood vaccines
177 Had a vaccine in the last 12 months
147 Had a flu shot last year
182 Had a pneumonia vaccine last year
183 Had a Hepatitis B vaccine in the last 2 years.
- Has a family history of:
- 184 Cancer
185 Heart Disease
186 Diabetes
187 Alcoholism
188 Depression
189 Obesity

Lifestyle & Environment

- Do you use? Well Water City Water Filtered? Yes No Filter Type? _____
What kind of pipes are in your home? Steel CPVC Copper Pex Other _____
What year was your home built? _____ Any renovations in the past year? _____
Do you use chlorine bleach or other heavy duty cleaners in your home/work? Yes No
Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? Yes No
Explain: _____
Have you ever worked around industrial solvents, chemicals or pesticides? Yes No
Explain: _____

- 380 Drinks beverages from a can
370 Drinks alcohol
371 Drinks caffeinated coffee
372 Drinks caffeinated pop/soda
373 Drinks caffeinated tea
374 Drinks decaffeinated coffee
375 Drinks decaffeinated pop/soda
376 Drinks decaffeinated tea
377 Drinks >3 cups of coffee daily
378 Drinks >3 cups of tea per day
388 Drinks diet pop/soda
- 379 Drinks >1 pop/sodas per day
I had 4 alcoholic drinks in one day:
172 never
173 more than 3 months ago
174 less than 3 months ago
381 Has >5 alcoholic drinks/week
391 Craves sugar / starches
382 Currently smokes
383 Quit smoking in last 5 years
384 Smoked for >5 years
385 Smokes >1 pack per day
- 126 Rarely exercises
133 Regularly exercises
386 Takes Vitamins
134 Vegetarian
135 Eats no red meat
136 Eats no meat, no dairy
387 Frequent use of artificial sweeteners
389 Anorexia
390 Bulimic

Surgeries

- | | | |
|--|--|--|
| 700 <input type="checkbox"/> Tonsillectomy and/or Adenoids | 707 <input type="checkbox"/> Breast implants | 714 <input type="checkbox"/> Splenectomy |
| 701 <input type="checkbox"/> Appendix | 708 <input type="checkbox"/> Cancer | 715 <input type="checkbox"/> Radiated thyroid |
| 702 <input type="checkbox"/> Gallbladder | 709 <input type="checkbox"/> Coronary by-pass | 716 <input type="checkbox"/> Cataract surgery |
| 703 <input type="checkbox"/> Thyroid | 710 <input type="checkbox"/> Spinal surgery | 717 <input type="checkbox"/> Hemorrhoidectomy |
| 704 <input type="checkbox"/> Hysterectomy, complete | 711 <input type="checkbox"/> Extremity surgery | 718 <input type="checkbox"/> Bariatric/Weight loss |
| 705 <input type="checkbox"/> Hysterectomy, partial | 712 <input type="checkbox"/> Hip replacement | Type: _____ |
| 706 <input type="checkbox"/> Tubal ligation | 713 <input type="checkbox"/> Knee replacement | |

Gastrointestinal

- | | |
|---|---|
| 265 <input type="checkbox"/> 4-5 bowel movements per week | 284 <input type="checkbox"/> Immediate indigestion upon eating |
| 266 <input type="checkbox"/> 3 or less bowel movements per week | 285 <input type="checkbox"/> Indigestion in 2 hours or more after meals |
| 267 <input type="checkbox"/> 6 or more bowel movements per week | 286 <input type="checkbox"/> Indigestion within 1 hour after meals |
| 268 <input type="checkbox"/> Black tarry stools | 287 <input type="checkbox"/> Difficulty swallowing |
| 269 <input type="checkbox"/> Pale or yellow colored stool | 288 <input type="checkbox"/> Eating relieves fatigue |
| 270 <input type="checkbox"/> Blood stools | 289 <input type="checkbox"/> Eats when nervous |
| 271 <input type="checkbox"/> Constipation | 290 <input type="checkbox"/> Excessive hunger |
| 272 <input type="checkbox"/> Hemorrhoids | 291 <input type="checkbox"/> Poor appetite |
| 273 <input type="checkbox"/> Loose bowel movements | 292 <input type="checkbox"/> Experiences fainting spells when hungry |
| 274 <input type="checkbox"/> Frequent diarrhea | 293 <input type="checkbox"/> Feels shaky when hungry |
| 275 <input type="checkbox"/> Frequent nausea | 294 <input type="checkbox"/> Frequently drowsy after eating a meal |
| 276 <input type="checkbox"/> Frequent vomiting | 295 <input type="checkbox"/> Gall bladder disease |
| 277 <input type="checkbox"/> Abdominal gas | 296 <input type="checkbox"/> Has had intestinal worms |
| 278 <input type="checkbox"/> Belching and burping after eating | 297 <input type="checkbox"/> Reflux/Hiatal hernia |
| 279 <input type="checkbox"/> Bloating after eating | 298 <input type="checkbox"/> Liver disease |
| 280 <input type="checkbox"/> Severe abdominal pains | 299 <input type="checkbox"/> Irritable Bowel Syndrome |
| 281 <input type="checkbox"/> Stomach ulcers | 300 <input type="checkbox"/> Diverticulitis |
| 282 <input type="checkbox"/> Uses digestive aids | 301 <input type="checkbox"/> Diverticulosis |
| 283 <input type="checkbox"/> Uses laxatives | |

Respiratory

- | | | |
|--|--|--|
| 485 <input type="checkbox"/> Catches severe colds | 491 <input type="checkbox"/> Frequent colds | 497 <input type="checkbox"/> Night sweats |
| 486 <input type="checkbox"/> Chronic chest condition | 492 <input type="checkbox"/> Frequent nose bleeds | 498 <input type="checkbox"/> Post nasal drip |
| 487 <input type="checkbox"/> Chronic cough | 493 <input type="checkbox"/> Frequent sinus infections | 499 <input type="checkbox"/> Sneezing spells |
| 488 <input type="checkbox"/> Constant runny nose | 494 <input type="checkbox"/> Frequent stuffy nose | 500 <input type="checkbox"/> Spits up blood |
| 489 <input type="checkbox"/> COPD | 495 <input type="checkbox"/> Hay fever | 501 <input type="checkbox"/> Spits up phlegm |
| 490 <input type="checkbox"/> Difficulty breathing | 496 <input type="checkbox"/> Nasal polyps | 502 <input type="checkbox"/> Wheezes |

Mouth and Throat

- | | | |
|---|--|--|
| 400 <input type="checkbox"/> Bad breath | 407 <input type="checkbox"/> Frequent fever blisters | 414 <input type="checkbox"/> Tongue has grooves or fissures |
| 401 <input type="checkbox"/> Bitter taste in the mouth in the morning | 408 <input type="checkbox"/> Frequent sore throats | 415 <input type="checkbox"/> Tongue is coated |
| 402 <input type="checkbox"/> Dry mouth | 409 <input type="checkbox"/> Frequently has a sore tongue | 416 <input type="checkbox"/> Gums bleed when brushing teeth |
| 403 <input type="checkbox"/> Excessive saliva | 410 <input type="checkbox"/> Sore gums | 417 <input type="checkbox"/> Toothaches |
| 404 <input type="checkbox"/> Sores or cracks in the corners of the mouth | 411 <input type="checkbox"/> Swollen gums | 418 <input type="checkbox"/> Amalgam dental fillings |
| 405 <input type="checkbox"/> Glands often swell | 412 <input type="checkbox"/> Swollen tongue | 420 <input type="checkbox"/> Other dental fillings (gold, composite, etc) |
| 406 <input type="checkbox"/> Frequent canker sores | 413 <input type="checkbox"/> Tongue burns | 419 <input type="checkbox"/> Has had root canal(s) |

Endocrine

- 245 Coarse hair
246 Coarse skin
247 Diabetic
248 Excessive thirst
249 Frequently feels cold
250 Frequently feels hot
251 Gets lightheaded when standing quickly
252 Heals slowly
253 Unusually jumpy or nervous
254 Unusually tired most of the time

Cardiovascular

- 190 Cold feet
191 Cold hands
192 Experiences shortness of breath while sitting still
193 Heart skips beats
194 Tendency of High blood pressure
195 Leg cramps during bedtime
196 Leg cramps during daytime
197 Low blood pressure at times
198 Pain in leg/hips when walking
199 Frequent swollen ankles
200 Pains in the heart or chest
201 Spells of rapid heart rate
202 Troubled with blood clots
203 Unusually slow pulse rate
204 Varicose veins
205 Heart palpitations

Skin

- 520 Bruises easily
521 Excessive perspiration
522 Frequent goose bumps
523 Has acne
524 Has Psoriasis
525 Hives
526 Itchy skin
527 Problems with Eczema
528 Has moles which are changing in size and/or color
530 Skin is rough, especially on the back of the arms
529 Skin eruptions
531 Skin is tender
532 Sores that heal slowly
533 Troubled with boils
534 Dry skin

Ears

- 220 Discharge from ears
221 Hard of hearing
222 Punctured ear drum
223 Recurrent ear infection
224 Ringing or noises in the ears
225 Tinnitus

Eyes

- 320 Bloodshot eyes
321 Blurred vision
322 Cross eyes
323 Eye pain
324 Eyes feel gritty
325 Eyes watery
326 Mild Glaucoma
327 Far sighted
328 Developing cataracts
329 Mild Macular degeneration
330 Itchy eyes
331 Near sighted
332 Dry Eyes

Feet

- 350 Corns
351 Frequent foot cramps
352 Heel spurs
353 Painful feet
354 Plantar warts
355 Swelling in the feet and/or ankles
356 Plantar fasciitis
357 Fungal Infection

Neuromuscular

- 440 Bites nails
441 Frequent muscle soreness
442 Muscle spasms
443 Muscle weakness
444 Tremors
445 Frequent headaches
446 Often dizzy
447 Frequently feels faint
448 Has Epilepsy
449 Has motion sickness
450 Has Osteoarthritis
451 Has Rheumatism
452 Rheumatoid Arthritis
453 Joint stiffness in the morning
454 Swollen joints
455 Leg pain at rest
456 Spinal curvature
457 Low back pain
458 Neck pain
459 Pain between the shoulders
460 Shoulder/arm pain
461 Numbness/tingling in the body
462 Sleep walks
463 Stutters or stammers
464 Nerve pain

Behavior Patterns

- 150 Afraid to eat anywhere except home
- 151 Always needs someone to advise
- 152 Cries often
- 153 Difficulty concentrating
- 154 Difficulty falling asleep
- 155 Difficulty staying asleep
- 156 Easily angered
- 157 Feelings are easily hurt
- 158 Frequently becomes scared for no reason
- 159 Frequently miserable or blue
- 160 Has to be on guard even with friends
- 161 Often annoyed by people
- 162 Recurrent bad dreams
- 163 Sometimes wishes to be dead or away from it all
- 164 Upset by criticism
- 165 Poor memory
- 166 Scared to be alone
- 167 Strange people or places cause fear
- 168 Under considerable emotional stress
- 169 Unhappy when others are happy
- 170 Brain fog

Urinary

- 555 Urinates more than 2 times per night
- 556 Bed wetting
- 557 Blood in the urine
- 558 Difficulty starting urination
- 559 Painful urination
- 560 Frequent urination
- 561 Troubled by urgent urination
- 562 Incontinence when sneezing or laughing
- 563 Loses bladder control
- 564 Frequent bladder infections
- 565 Frequent kidney infections
- 566 Kidney stones

Men Only

- 585 Difficulty completing intercourse
- 586 Difficulty getting or keeping an erection
- 587 Discharge from the urethra
- 588 Had a vasectomy
- 589 Had difficulty fathering children
- 590 Lumps in the testicles
- 591 Painful genitals
- 592 Prostate troubles
- 593 Sores on external genitalia
- 594 Herpes
- 595 Sexual diseases

Women Only

- 610 Heavy hair growth on face or body
- 611 Cycles are every 27-29 days
- 612 Abnormal cycle >29 days and/or <26 days
- 613 PMS
- 614 Menstrual cramps
- 615 Painful periods
- 616 Acne worse at menstruation
- 617 Excessive menstrual flow
- 618 Retains fluid during periods
- 619 Pre-menstrual depression
- 620 Currently taking birth control medication
- 621 Has taken birth control medication more than 1 year
- 622 Has taken birth control medication within the last year
- 623 Has had miscarriage
- 624 Hot flashes
- 625 Takes hormone replacement medication
- 627 Diminished sexual desire
- 628 Painful intercourse
- 629 Poor or infrequent orgasm
- 630 Lumps in the breasts
- 631 Tender breasts
- 633 Vaginal discharge
- 634 Bloody spotting discharge
- 635 Yeast infections
- 636 Sores on external genitalia
- 637 Herpes
- 638 Sexual diseases
- 639 Endometriosis
- 640 Breast reduction
- 641 Breast augmentation
- 642 Abortion
- 643 D&C
- 644 Tubal pregnancy
- 645 Uterine fibroids
- 646 Ovarian fibroids
- 647 Breast fibroids
- 648 Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

| <u>DRUG</u> | <u>PRESCRIBED FOR:</u> | <u>HOW LONG</u> |
|-------------|------------------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

| <u>DRUG</u> | <u>PRESCRIBED FOR:</u> | <u>HOW LONG</u> |
|-------------|------------------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

| | | | |
|--------------------------------------|---------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Gluten | <input type="checkbox"/> Ragweed | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Mold | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Tree nuts |
| <input type="checkbox"/> Garlic | <input type="checkbox"/> Peanut | <input type="checkbox"/> Soy | <input type="checkbox"/> Wheat |
| <input type="checkbox"/> Other _____ | | | |

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

| <u>VITAMIN</u> | <u>BRAND</u> | <u>DOSAGE</u> |
|----------------|--------------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |