Springbrook Chiropractic & Natural Health Center
420 Villa Road (Mail to P.O. Box 1022) Newberg, Oregon 97132
John J. Collins, DC

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):