Expanded Health Questionnaire

Patient Name _____Date_____

What brought you here? _____

How long have you been suffering from this problem? (Major complaint) _____

How often do you find yourself suffering from this problem? (Each complaint)

- (major complaint) _____
- _____
- _____
- _____

Earlier accidents? Broken bones? MVA's? Knocked unconscious? Stitches?

_____
_____
_____

What if anything, have you tried that **did not work**? (i.e.: Ice, Heat, Rest, Over the Counter Meds, Prescriptions, P.T., Chiropractic, other)

_____
_____
_____

How does this affect doing any of your daily activities/hobbies?

_____
_____

We are really glad you came here, you made the right decision.

This is the place for you to **"regain your life!"**