Frederick G. Mayer, DC
508 Main Street
Avon, NJ 07717
732-988-8596

CONFIDENTIAL HEALTH QUESTIONNAIRE

Patient's Name ____________________ **DOB** __________ **Date** ________

What is your chief complaint(s)? ______________________________

Healthcare you have utilized in the past for your complaint(s): ☐ Chiropractic ☐ Physical Therapy ☐ Massage
☐ Acupuncture ☐ Herbal Medicine / Homeopathy / Naturopathy ☐ Prescription / Non-Prescription Drugs
☐ Surgery ☐ Other ______________________________
Which healthcare approaches had favorable results? Unfavorable results? ______________________________
____

What other health problems (including fractures and dislocations) do you have, or have you had in the past?
____
____

Smoking Status: ☐ I was never a smoker ☐ I currently smoke ☐ I'm a former smoker

Allergies: ☐ I Have No Known Allergies

☐ Dairy	☐ Mold	☐ Soy	☐ Other allergies
☐ Eggs	☐ Peanut	☐ Sulfa drugs	________________
☐ Garlic	☐ Ragweed	☐ Tree nuts	
☐ Gluten	☐ Shellfish	☐ Wheat	

List all drugs you are currently taking daily, including prescription and over the counter medications. Also, list the condition for which it was prescribed or recommended and how long you have taken each medication:

Medication -	Prescribed or Recommended for -	How long -

List all drugs you had taken within the last year or take only as needed (including IMMUNIZATIONS). Also, list the condition for which it was prescribed or recommended and how long/when you had taken each medication:

Medication -	Prescribed or Recommended for -	How long/When -

List all vitamin, herbal, and other nutritional supplements you are currently taking, and how much you take daily:

Supplement / Brand / How much -	Supplement / Brand / How much -

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Patient's Name ____ **DOB** ______________ **Date** ________

Are you pregnant? ▢ no ▢ yes **# of weeks** _____

Surgeries:

▢ Tonsillectomy and/or Adenoids
▢ Appendix
▢ Gallbladder
▢ Thyroid
▢ Hysterectomy, complete
▢ Hysterectomy, partial
▢ Tubal ligation
▢ Breast implants
▢ Cancer
▢ Coronary by-pass
▢ Spinal surgery
▢ Extremity surgery
▢ Hip replacement
▢ Knee replacement
▢ Splenectomy
▢ Radiated thyroid
▢ Cataract surgery
▢ Hemorrhoidectomy
▢ Bariatric/Weight loss
Type: _________________
Other surgeries _________________
____

Describe your typical exercise routine (what type / how often) ____
____
____

Mark your level of activity on the job or at home:

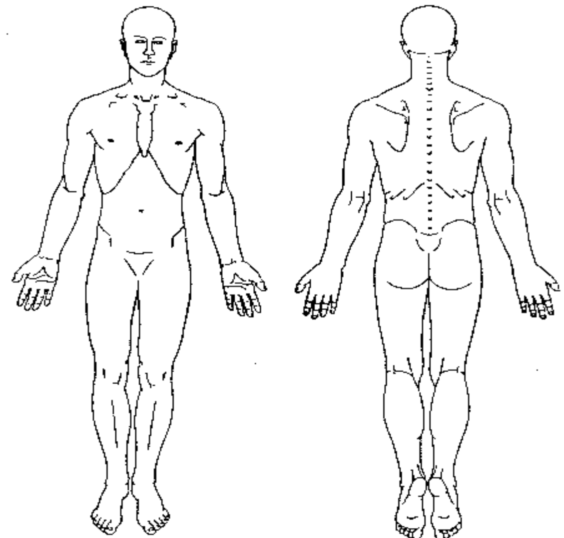
▢ mostly sitting / occasionally lifting 10 lbs maximum, with brief periods of walking & standing
▢ light work / occasionally lifting 20 lbs maximum, with frequent lifting & carrying up to 10 lbs
▢ medium work / occasionally lifting 50 lbs maximum, with frequent lifting & carrying up to 25 lbs
▢ heavy work / occasionally lifting 100 lbs maximum, with frequent lifting & carrying up to 50 lbs
▢ very heavy work / occasionally lifting over 100 lbs, with frequent lifting & carrying over 50 lbs

What would you hope to do better, enjoy more of, or accomplish if you didn't have this health problem?
____
____

Family (parents, siblings, children) health history, living or deceased:

▢ Cancer
▢ Heart Disease
▢ Diabetes
▢ Alcoholism
▢ Depression
▢ Obesity

Mark the location of your complaints, including pain, numbness and weakness, on the body drawings ⇨



Mark the line below to show how much pain you are experiencing at the present time:

|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
no pain **worst imaginable pain**

Physician Initials _____