

COMPREHENSIVE HEALTH QUESTIONNAIRE

INSTRUCTIONS: PLEASE ANSWER THE FOLLOWING QUESTIONS, YES, IF YOU HAVE OR HAVE HAD PROBLEMS
NO, IF YOU HAVE NEVER HAD A PROBLEM.

PATIENT NAME: _____

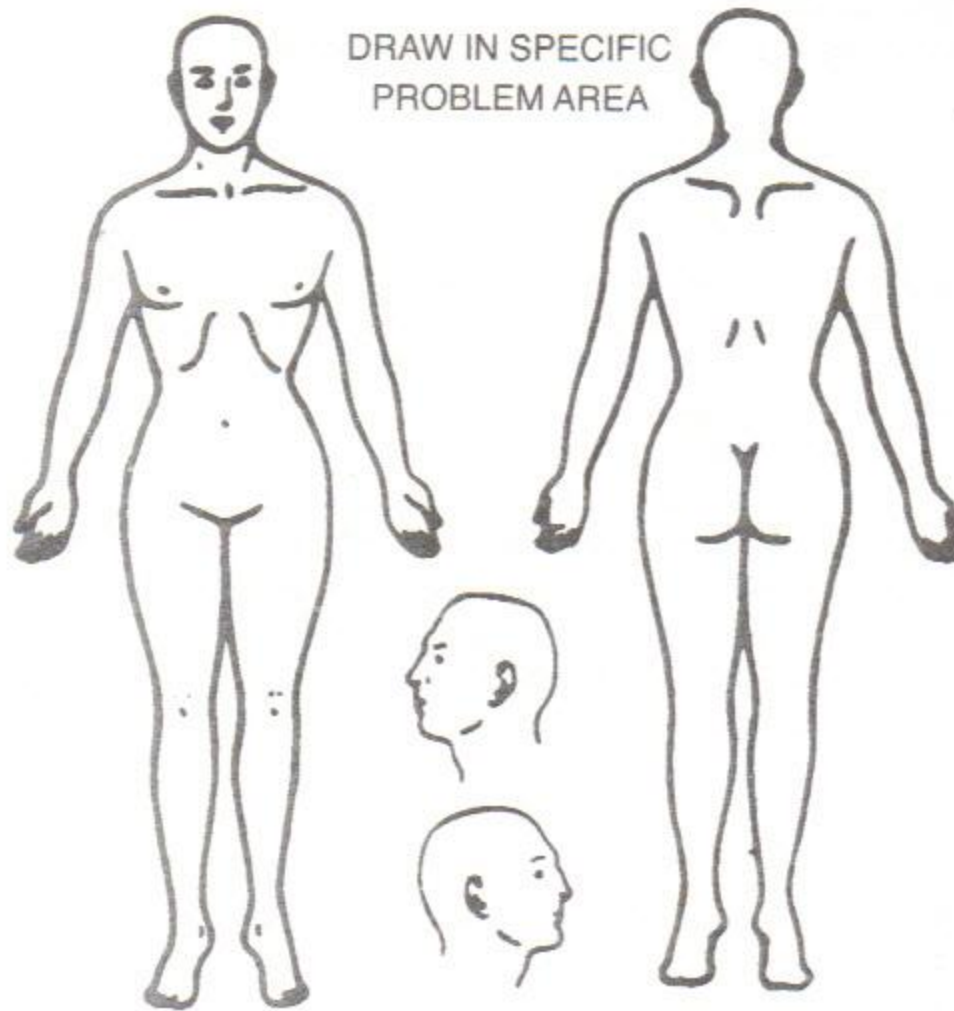
- DO YOU EXERCISE REGULARLY? YES ___ NO ___
 DO YOU SUFFER FROM SEVERE HEADACHES? YES ___ NO ___
 DO YOU HAVE CONVULSIONS OR EPILEPSY? YES ___ NO ___
 PARTS OF YOUR BODY EVER PARALYZED? YES ___ NO ___
 WERE YOU EVER KNOCKED UNCONSCIOUS? YES ___ NO ___
 DO YOU HAVE DIFFICULTY SLEEPING? YES ___ NO ___
 DO YOU SMOKE OR DRINK EXCESSIVELY? YES ___ NO ___
 DO YOU DRINK A LOT OF COFFEE? YES ___ NO ___
 DO YOU HAVE SPELLS OF EXHAUSTION? YES ___ NO ___
 DO YOU GET UP TIRED IN THE MORNING? YES ___ NO ___
 ARE YOU FREQUENTLY ILL? YES ___ NO ___
 HAVE YOU HAD ANY OF THE FOLLOWING WITHIN THE LAST YEAR?
 A. COMPLETE PHYSICAL EXAMINATION YES ___ NO ___
 B. HEART EXAMINATION YES ___ NO ___
 C. BLOOD PRESSURE CHECK YES ___ NO ___
 D. MEDICAL CARE YES ___ NO ___
 E. CHIROPRACTIC CARE YES ___ NO ___
 DOES ARTHRITIS RUN IN YOUR FAMILY? YES ___ NO ___
 DO YOU GET UP AT NIGHT AND URINATE? YES ___ NO ___
 DO YOU BLACK OUT OR FAINT? YES ___ NO ___
 IS THERE CONSTANT NOISE IN EARS? YES ___ NO ___
 DO YOU HAVE SINUS PROBLEMS? YES ___ NO ___
 DO YOU HAVE ALLERGYS? YES ___ NO ___
 DO YOU COUGH UP BLOOD? YES ___ NO ___
 DO YOU HAVE NIGHT SWEATS? YES ___ NO ___
 PAINS IN THE HEART OR CHEST? YES ___ NO ___
 DIFFICULTY IN BREATHING? YES ___ NO ___
 OUT OF BREATH BEFORE ANYONE ELSE? YES ___ NO ___
 ANKLES BADLY SWOLLEN? YES ___ NO ___
 SUFFER FROM CRAMPS ON YOUR LEGS? YES ___ NO ___
 DO YOU HAVE HEART TROUBLE? YES ___ NO ___
 DO YOU HAVE BADLY COATED TONGUE? YES ___ NO ___
 DO YOU EAT SWEETS BETWEEN MEALS? YES ___ NO ___
 SUFFER FROM INDIGESTION? YES ___ NO ___
 DOUBLE UP FROM SEVERE STOMACH PAINS? YES ___ NO ___
 LOOSE BOWEL MOVEMENTS? YES ___ NO ___
 BAD CONSTIPATION? YES ___ NO ___
 PAINFUL MENSTRUAL PERIODS? YES ___ NO ___
 SEVERE HOT FLASHES AND SWEATS? YES ___ NO ___
 RECENT AND RAPID WEIGHT LOSS? YES ___ NO ___

HEIGHT _____ WEIGHT _____

(Circle One)

ACTIVITY LEVEL: Sedentary - Active - Very Active

STRESS LEVEL: Minimal - Moderate - Great



P PAIN-CONSTANT OR FREQUENT (MAIN PROBLEM)

C PAIN-OFF & ON, INFREQUENT OR CHRONIC

N NUMBNESS, TINGLING, OR BURNING

ADDITIONAL COMMENTS _____

FAMILY HEALTH HISTORY RECORD

NAME & ADDRESS	DATE OF BIRTH	HEALTH HISTORY	
		PREVIOUS YEARS	PRESENT
HUSBAND OR WIFE:			
CHILDREN:			
MOTHER:			
FATHER:			
SISTERS: BROTHERS:			

IN CASE OF EMERGENCY, WHO CAN WE CALL OTHER THAN YOUR HOME?

NAME _____ ADDRESS _____ RELATIONSHIP _____ HOME PH. _____ WORK H. _____

CURRENT MEDICAL DOCTOR? _____ PHONE # _____

WHICH HOSPITAL WOULD YOU PREFER IN CASE OF AN EMERGENCY? _____

PATIENT INTRODUCTION CARD

Date: _____ Patient # _____
Patient Name: Last _____ First _____ Init. _____
Address: _____ City _____ State _____ Zip _____
Phone: () _____ Birthdate: ____/____/____ Age _____
Sex: (M-male, F-female): _____ Marital Status: M S W D Patient Soc. Sec. #: _____
Patient Employed By: _____
Occupation: _____ Business Phone: () _____
Insurance Coverage: _____ Spouses Birthdate: ____/____/____
Referred By: _____
Briefly Describe Chief Complaint (Symptoms) _____

How did it happen? _____
How would you rate your pain today (0 being no pain and 10 being the worst pain) _____
What have you done to try to help this problem so far? _____
Have you ever had same or similar complaint? Yes or No Explain _____
List all other health problems and symptoms you are having: _____

List all past surgeries _____
List all medications you are currently taking _____ for _____ for _____
_____ for _____ for _____ for _____

Have you been to a chiropractor before? Yes or No If Yes, for what? _____
FEMALES ONLY: To your knowledge are you pregnant? Yes or No (Circle One)
Are You Claiming Workmen's Compensation: YES _____ NO _____
Are You Claiming Auto Accident: YES _____ NO _____
Company or Insurance Name: _____
Address: _____ Phone #: () _____

Patient Signature _____

- I Am Interested in Only Symptomatic Relief (Feel Better)
- I Am Interested in Symptomatic Relief, and Maximum Correction of My Problem
- I Am Interested in Symptomatic Relief, Maximum Correction and a Health Maintenance Plan

Do You Have Any Problems With The Following PRESENT PAST

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hay fever | <input type="checkbox"/> T.B. | <input type="checkbox"/> Menstrual cramps, pain |
| <input type="checkbox"/> Arterio sclerosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tightness of throat | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Cervical arthritis | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Chest and left arm pain | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Recent severe neck strain | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Anemia | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Family history of strokes | <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Dizziness or unsteadiness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Fainting or lightheadedness | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Ruptured disc |
| <input type="checkbox"/> Temporary loss of memory | <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Previous disc surgery |
| <input type="checkbox"/> Numbness in face or arms | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Nerves, nervousness | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Garbled speech | <input type="checkbox"/> Increased pain to cough, sneeze | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Irritability | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Recent severe, sudden head pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Numbness in legs |
| <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Pins and needles in arms, hands | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Pains in legs & feet |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Kidney trouble | |

ANY FALLS, ACCIDENTS, INJURIES? YES NO
If yes, please explain _____

Please specify the Doctor of your choice: _____
PLEASE RETURN THIS FORM WITH YOUR INSURANCE CARD TO FRONT DESK